Federal Register

Thursday,
August 1, 2002

Part II

Department of Health and Human Services

Centers for Medicare and Medicaid Services

42 CFR Part 405, et al.

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, and 485

[CMS–1203–F]

RIN 0938–AL23

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: We are revising the Medicare acute care hospital inpatient prospective payment systems for operating and capital costs to implement changes arising from our continuing experience with these systems. In addition, in the Addendum to this final rule, we describe the changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes are applicable to discharges occurring on or after October 1, 2002. We also are setting forth rate-of-increase limits as well as policy changes for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment systems.

In addition, we are setting forth changes to other hospital payment policies, which include policies governing: Payments to hospitals for the direct and indirect costs of graduate medical education; pass-through payments for the services of nonphysician anesthetists in some rural hospitals; clinical requirements for swing-bed services in critical access hospitals (CAHs); and requirements and responsibilities related to provider-based entities.

DATES: The provisions of this final rule are effective on October 1, 2002. This rule is a major rule as defined in 5 U.S.C. 804(2). Pursuant to 5 U.S.C. 801(a)(1)(A), we are submitting a report to Congress on this rule on August 1, 2002.

FOR FURTHER INFORMATION CONTACT:

Stephen Phillips, (410) 786–4548, Operating Prospective Payments, Diagnosis-Related Groups (DRGs), Wage Index, New Medical Services and Technology, Hospital Geographic Reclassifications, and Postacute Transfer Issues.

Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, Graduate Medical Education, Provider-Based Entities, Critical Access Hospital (CAH).

Stephen Heffler, (410) 786–1211, Hospital Market Basket Rebasing.

Jeannie Miller, (410) 786–3164, Clinical Standards for CAHs.

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $9.00. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access,* a service of the U.S. Government Printing Office. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents home page address is *http://www.access.gpo.gov/nara_docs/,* by using local WAIS client software, or by telnet to swais.access.gpo.gov, then login as guest (no password required). Dial-in users should use communications software and modem to call (202) 512–1661; type swais, then login as guest (no password required).

I. Background

A. Summary

1. Acute Care Hospital Inpatient Prospective Payment System

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system. Under these prospective payment systems, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

The base payment rate is comprised of an average standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located; and if the hospital is located in Alaska or Hawaii, the nonlabor share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital is recognized as serving a disproportionate share of low-income patients, it receives a percentage add-on payment for each case paid through the acute care hospital inpatient prospective payment system. This percentage varies, depending on several factors which include the percentage of low-income patients served. It is applied to the DRG-adjusted base payment rate, plus any outlier payments received.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid through the acute care hospital inpatient prospective payment system. This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies that have been approved for special add-on payments. To qualify, the technologies must be shown to be a substantial clinical improvement over technologies otherwise available and that they would be inadequately paid otherwise (absent the add-on payments) under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate.

Although payments to most hospitals under the acute care hospital inpatient prospective payment system are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of Federal fiscal year (FY) 1982, FY 1987, or FY 1996) or the prospective payment system rate based on the standardized amount. For example, sole community hospitals (SCHs) are the sole source of care in their areas, and Medicare-dependent, small rural hospitals (MDHs) are a major

source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries (although MDHs receive only 50 percent of the difference between the prospective payment system rate and their hospital-specific rates, if the hospital-specific rate is higher than the prospective payment system rate).

The existing regulations governing payments to hospitals under the acute care hospital inpatient prospective payment system are located in 42 CFR Part 412, Subparts A through M.

2. Hospitals and Hospital Units Excluded from the Acute Care Hospital Inpatient Prospective Payment System

Under section 1886(d)(1)(B) of the Act, as amended, certain specialty hospitals and hospital units are excluded from the acute care hospital inpatient prospective payment system. These hospitals and units are: psychiatric hospitals and units; rehabilitation hospitals and units; long-term care hospitals; children's hospitals; and cancer hospitals. Various sections of the Balanced Budget Act of 1997 (Pub. L. 105–33), the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) provide for the implementation of prospective payment systems for rehabilitation hospitals and units, psychiatric hospitals and units, and long-term care hospitals, as discussed below. Children's hospitals and cancer hospitals will continue to be paid on a cost-based reimbursement basis.

The existing regulations governing payments to excluded hospitals and hospital units are located in 42 CFR Parts 412 and 413.

Under section 1886(j) of the Act, as amended, rehabilitation hospitals and units are being transitioned from a blend of reasonable cost-based reimbursement subject to a hospital-specific annual limit under section 1886(b) of the Act and Federal prospective payments for cost reporting periods beginning January 1, 2002 through September 30, 2002, to payment on a fully Federal prospective rate effective for cost reporting periods beginning on or after October 1, 2002 (66 FR 41316, August 7, 2001). The statute also provides that, for cost reporting periods beginning in FY 2003, inpatient rehabilitation facilities that are subject to the blend methodology may elect to receive the full prospective payment instead of a blended payment. The existing regulations governing payment under the inpatient rehabilitation facility prospective payment system (for rehabilitation hospitals and units) are located in 42 CFR Part 412, Subpart P.

Under the broad authority conferred to the Secretary by section 123 of Public Law 106–113 and section 307(b) of Public Law 106–554, we are proposing to transition long-term care hospitals from payments based on reasonable cost-based reimbursement under section 1886(b) of the Act to fully Federal prospective rates during a 5-year period. For cost reporting periods beginning on or after October 1, 2006, we are proposing to pay long-term care hospitals under the fully Federal prospective payment rate. (See the proposed rule issued in the **Federal Register** on March 22, 2002 (67 FR 13416).) Under the proposed rule, during the transition, long-term care hospitals subject to the blend methodology would also be permitted to elect to be paid based on full Federal prospective rates. The final regulations governing payments under the long-term care hospital prospective payment system are under development and will be located in 42 CFR Part 412, Subpart O.

Sections 124(a) and (c) of Public Law 106–113 provide for the development of a per diem prospective payment system for payment for inpatient hospital services furnished by psychiatric hospitals and units under the Medicare program, effective for cost reporting periods beginning on or after October 1, 2002. This system must include an adequate patient classification system that reflects the differences in patient resource use and costs among these hospitals and must maintain budget neutrality. We are in the process of developing a proposed rule, to be followed by a final rule, to implement the prospective payment system for psychiatric hospitals and units.

3. Critical Access Hospitals

Under sections 1814, 1820, and 1834(g) of the Act, payments are made to critical access hospitals (CAHs) (that is, rural hospitals or facilities that meet certain statutory requirements) for inpatient and outpatient services on a reasonable cost basis. Reasonable cost is determined under the provisions of section 1861(v)(1)(A) of the Act and existing regulations under 42 CFR Parts 413 and 415.

4. Payments for Graduate Medical Education

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act; the amount of payment for direct GME costs for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year.

The existing regulations governing GME payments are located in 42 CFR Part 413.

B. Summary of the Provisions of the May 9, 2002 Proposed Rule

On May 9, 2002, we published a proposed rule in the **Federal Register** (67 FR 31404) that set forth proposed changes to the Medicare hospital inpatient prospective payment systems for operating costs and for capital-related costs in FY 2003. We also set forth proposed changes relating to payments for GME costs; payments to excluded hospitals and units; policies implementing the Emergency Medical Treatment and Active Labor Act (EMTALA); clinical requirements for swing beds in CAHs; and other hospital payment policy changes. These proposed changes would be effective for discharges occurring on or after October 1, 2002.

The following is a summary of the major changes that we proposed and the issues we addressed in the May 9, 2002 proposed rule:

1. Changes to the DRG Reclassifications and Recalibrations of Relative Weights

As required by section 1886(d)(4)(C) of the Act, we proposed annual adjustments to the DRG classifications and relative weights. Based on analyses of Medicare claims data, we proposed to establish a number of new DRGs and to make changes to the designation of diagnosis and procedure codes under other existing DRGs.

Among the proposed changes discussed were:

- Revisions of DRG 1 (Craniotomy Age >17 Except for Trauma) and DRG 2 (Craniotomy for Trauma Age >17) to reflect the current assignment of cases involving head trauma patients with other significant injuries to major diagnostic category (MDC) 24.
- Reconfiguration and retitling of existing DRG 14 (Specific Cerebrovascular Disorders Except Transient Ischemic Attack) and DRG 15

(Transient Ischemic Attack and Precerebral Occlusions) and creation of a new DRG 524 (Transient Ischemia).

- Creation of a new DRG 525 (Heart Assist System Implant) for heart assist devices.
- Reassignment of the diagnosis code for rheumatic heart failure with cardiac catheterization.
- Assignment of new, and reassignment of existing, cystic fibrosis principal diagnosis codes.
- Redesignation of a code for insertion of totally implantable vascular access device (VAD) as an operating room procedure.
- Changes in the DRG assignment for the bladder reconstruction procedure code.
- Changes in DRG and MDC assignments for numerous newborn and neonate diagnosis codes. (We note that, based on public comments received on the proposed rule, we are not making these changes in this final rule, as discussed in section II.B.6. of this preamble.)
- Changes in DRG assignment for cases of tracheostomy and continuous mechanical ventilation greater than 96 hours.
- We also discussed other DRG classification issues for which we did not propose changes. One of those was the new drug-eluting stent technology. We received many public comments suggesting higher payments would be needed in order to adequately compensate hospitals for the higher costs of this technology. Therefore, in this final rule, we are creating new DRG 525 (Percutaneous Cardiovascular Procedure with, Drug-Eluting Stent with AMI) and new DRG 527 (Percutaneous Cardioascular Procedure with Drug-Eluting Stent without AMI).

We also presented our analysis of applicants for add-on payments for high-cost new medical technologies. We have approved one new technology, the drug drotrecogin alfa (activated), trade name Xigris™, as a new technology eligible for add-on payments. Xigris™ is used to treat patients with severe sepsis.

2. Changes to the Hospital Wage Index

We proposed revisions to the wage index and the annual update of the wage data. Specific issues addressed in this section included the following:

- The FY 2003 wage index update, using FY 1999 wage data.
- Exclusion from the wage index of Part A physician wage costs that are teaching-related, as well as resident and Part A certified registered nurse anesthetist (CRNA) costs.
- Collection of data for contracted administrative and general, housekeeping, and dietary services.
- Revisions to the wage index based on hospital redesignations and reclassifications by the Medicare Geographic Classification Review Board (MGCRB).
- Requests for wage data corrections, including clarification of our policies on mid-year corrections.

3. Revision and Rebasing of the Hospital Market Basket

We proposed rebasing and revising the hospital market basket to be used in developing the FY 2003 update factor for the operating prospective payment rates and the excluded hospital rate-of-increase limits. We also set forth the data sources used to determine the revised market basket relative weights and choice of price proxies.

In the proposed rule, we also reestimated the labor-related share of the average standardized amount that is adjusted by the wage index. In response to public comments received recommending further evaluation of the methodology used to estimate the labor-related share, we are not proceeding with that reestimation in this final rule.

4. Other Decisions and Changes to the Prospective Payment System for Inpatient Operating and Graduate Medical Education Costs

We discussed several provisions of the regulations in 42 CFR Parts 412 and 413 and set forth certain proposed changes concerning the following:

- Options for expanding the postacute care transfer policy. Based on public comments received, we are not expanding the policy at this time.
- Clarification of the application of the statutory provisions on the calculation of hospital-specific rates for SCHs.
- Exclusion of certain limited-service specialty hospitals from the like hospital definition for purposes of granting SCH status. We proposed to set the threshold for determining a specialty hospital is not a like hospital at 3 percent service overlap between the SCH and the specialty hospital. In this final rule, in response to public comments, we are establishing that threshold at 8 percent.
- Technical change regarding additional payments for outlier cases.
- Proposed case-mix index values for FY 2003 for rural referral centers.
- Changes relating to the IME adjustment, including resident-to-bed ratio caps and counting beds. (We note that because of the need for a future comprehensive analysis on bed and patient day counting policies, and our limited timeframe for preparing the FY 2003 final rule for the acute care hospital inpatient prospective payment systems for publication by the statutory deadline of August 1, 2002, we have decided to postpone finalizing the proposed changes and will address the comments in a separate document.)
- Clarification and codification of classification requirements for MDHs and intermediary evaluations of cost reports for these hospitals.
- Changes to policies on pass-through payments for the costs of nonphysician anesthetists in some rural hospitals.
- Clarification of policies relating to implementing 3-year reclassifications of hospitals and other policies related to hospital reclassification decisions made by the MGCRB.
- Changes relating to payment for the direct costs of GME.
- Changes relating to emergency medical conditions in hospital emergency departments under the EMTALA provisions. (We note that because of the number and nature of the public comments we received on these proposed changes and our limited timeframe for preparing the FY 2003 final rule for the acute care hospital inpatient prospective payment systems for publication by the statutory deadline of August 1, we have decided to postpone finalizing the proposed changes and will address the comments in a separate document.)
- Criteria for, and responsibilities related to, payments for provider-based entities.
- CMS-directed reopening of intermediary determinations and hearing decisions on provider reimbursements.

We proposed to revise our methodology used to determine the fixed-loss cost threshold for outlier cases based on a 3-year average of the rates of change in hospitals' costs. We received many public comments opposing this change. In this proposed rule, we are using a 2-year average of the rate of change in charges to establish the threshold.

5. Prospective Payment System for Capital-Related Costs

We proposed payment requirements for capital-related costs effective October 1, 2002, which included:

- Capital-related costs for new hospitals.
- Additional payments for extraordinary circumstances.
- Restoration of the 2.1 percent reduction to the standard Federal capital prospective payment system rate.

• Clarification of the special exceptions payment policy.

6. Changes for Hospitals and Hospital Units Excluded From the Prospective Payment Systems

We discussed the following proposals concerning excluded hospitals and hospital units and CAHs:

• Payments for existing excluded hospitals and hospital units for FY 2003.

• Updated caps for new excluded hospitals and hospital units.

• Revision of criteria for exclusion of satellite facilities from the acute care hospital inpatient prospective payment system.

• The prospective payment systems for inpatient rehabilitation hospitals and units and long-term care hospitals.

• Changes in the advance notification period for CAHs electing the optional payment methodology.

• Removal of the requirement on CAHs to use a State resident assessment instrument (RAI) for patient assessments for swing-bed patients.

7. Determining Prospective Payment Operating and Capital Rates and Rate-of-Increase Limits

In the Addendum to the May 9, 2002 proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2003 prospective payment rates for operating costs and capital-related costs. We also proposed threshold amounts for outlier cases. In addition, we proposed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2003 for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system.

8. Impact Analysis

In Appendix A of the proposed rule, we set forth an analysis of the impact that the proposed changes would have on affected entities.

9. Report to Congress on the Update Factor for Hospitals Under the Prospective Payment System and Hospitals and Units Excluded From the Prospective Payment System

In Appendix B of the proposed rule, as required by section 1886(e)(3) of the Act, we set forth our report to Congress on our initial estimate of a recommended update factor for FY 2003 for payments to hospitals included in the acute care hospital inpatient prospective payment system, and hospitals excluded from this prospective payment system.

10. Recommendation of Update Factor for Hospital Inpatient Operating Costs

In Appendix C of the proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we included our recommendation of the appropriate percentage change for FY 2003 for the following:

• Large urban area and other area average standardized amounts (and hospital-specific rates applicable to SCHs and MDHs) for hospital inpatient services paid under the prospective payment system for operating costs.

• Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system.

11. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, the Medicare Payment Advisory Commission (MedPAC) is required to submit a report to Congress, not later than March 1 of each year, that reviews and makes recommendations on Medicare payment policies. This annual report makes recommendations concerning hospital inpatient payment policies. In the proposed rule, we discussed the MedPAC recommendations concerning hospital inpatient payment policies and presented our response to those recommendations. For further information relating specifically to the MedPAC March 1 report or to obtain a copy of the report, contact MedPAC at (202) 653–7220 or visit MedPAC's Web site at: *www.medpac.gov.*

C. Public Comments Received in Response to the May 9, 2002 Proposed Rule

We received approximately 1,196 timely items of correspondence containing multiple comments on the May 9, 2002 proposed rule. Summaries of the public comments and our responses to those comments are set forth below under the appropriate heading.

II. Changes to DRG Classifications and Relative Weights

A. Background

Under the acute care hospital inpatient prospective payment system, we pay for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG relative to the average resources used to treat cases in all DRGS.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. Changes to the DRG classification system and the recalibration of the DRG weights for discharges occurring on or after October 1, 2002 are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the acute care hospital inpatient prospective payment system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM).

For FY 2003, cases are assigned to one of 510 DRGs in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body. For example, MDC 6 is Diseases and Disorders of the Digestive System. However, some MDCs are not constructed on this basis because they involve multiple organ systems (for example, MDC 22 (Burns)).

In general, cases are assigned to an MDC based on the patients' principal diagnosis before assignment to a DRG. However, for FY 2003, there are eight DRGs to which cases are directly assigned on the basis of ICD–9–CM procedure codes. These are the DRGs for heart, liver, bone marrow, lung transplants, simultaneous pancreas/kidney, and pancreas transplants (DRGs 103, 480, 481, 495, 512, and 513, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483). Cases are assigned to these DRGs before classification to an MDC.

Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Surgical DRGs are based on a

hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures, by resource intensity. Medical DRGs generally are differentiated on the basis of diagnosis and age. Some surgical and medical DRGs are further differentiated based on the presence or absence of complications or comorbidities (CC).

Generally, nonsurgical procedures and minor surgical procedures not usually performed in an operating room are not treated as O.R. procedures. However, there are a few non-O.R. procedures that do affect DRG assignment for certain principal diagnoses, such as extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

Patients' diagnosis, procedure, discharge status, and demographic information is fed into the Medicare claims processing systems and subjected to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG.

After screening through the MCE and any further development of the claims, cases are classified into the appropriate DRG by the Medicare GROUPER software program. The GROUPER program was developed as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and, for a limited number of DRGs, demographic information (that is, sex, age, and discharge status). The GROUPER is used both to classify current cases for purposes of determining payment and to classify past cases in order to measure relative hospital resource consumption to establish the DRG weights.

The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and Review (MedPAR) file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights. However, in the July 30, 1999 final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for the use of particular data to be feasible, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the data submitted. Generally, however, a significant sample of the data should be submitted by mid-October, so that we can test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted no later than December 1 for consideration in conjunction with next year's proposed rule.

We proposed numerous changes to the DRG classification system for FY 2003. The proposed changes, the public comments we received concerning them, and the final DRG changes and the methodology used to recalibrate the DRG weights are set forth below. Unless otherwise noted, the changes we are implementing will be effective in the revised GROUPER software (Version 20.0) to be implemented for discharges on or after October 1, 2002. Also, unless otherwise noted, we are relying on the DRG data analysis in the proposed rule for the changes discussed below.

2. MDC 1 (Diseases and Disorders of the Nervous System)

a. Revisions of DRGs 1 and 2

Currently, adult craniotomy patients are assigned to either DRG 1 (Craniotomy Age >17 Except for Trauma) or DRG 2 (Craniotomy for Trauma Age >17). The trauma distinction recognizes that head trauma patients requiring a craniotomy often have multiple injuries affecting other body parts. However, we note that the structure of these DRGs predates the creation in FY 1991 of MDC 24 (Multiple Significant Trauma). The creation of MDC 24 resulted in head trauma patients with other significant injuries being assigned to MDC 24 and removed from DRG 2. In FY 1990, there was a 16-percent difference in the DRG weights for DRG 1 and DRG 2. In FY 1992, after the creation of MDC 24, the percentage difference in the DRG weights for DRG 1 and DRG 2 had declined to 1.2 percent. The FY 2002 payment weight for DRG 1 is 3.2713 and for DRG 2 is 3.3874, a 3.5 percent difference.

For FY 2003, we reevaluated the GROUPER logic for DRGs 1 and 2 by combining the patients assigned to these DRGs and examining the impact of other patient attributes on patient charges. The presence or absence of a CC was found to have a substantial impact on patient charges.

Cases in DRGs 1 and 2	Number of patients	Average charges
With CC	19,012	$49,659
Without CC	9,618	26,824

Thus, there is an 85.1 percent difference in average charges for the groups with and without CC for the combined DRGs 1 and 2. On this basis, we proposed to redefine and retitle DRGs 1 and 2 as follows: DRG 1 (Craniotomy Age >17 with CC); and DRG 2 (Craniotomy Age >17 without CC).

Comment: Nine commenters addressed this proposal. Three of the commenters supported the proposal. One commenter was concerned about the significant redefinition of DRGs to the extent that longitudinal DRG data analysis would be seriously comprised. This commenter recommended that we consider creating new DRGs when significant changes to the structure of existing DRGs are necessary in order to preserve the core definition of the existing DRGs for data analysis purposes. The commenter believed that this proposed revision would significantly alter the definition of these DRGs.

Response: We appreciate the support of the commenters for our position on this issue. In response to the commenter's concern that this revision would significantly alter the definition of these DRGs, thus affecting longitudinal DRG data analysis, our practice in the past has been to alter current DRGs to account for better clinical coherence as well as similar patterns of resource intensity. For example, last year we removed defibrillator cases from DRGs 104 and 105 to make these DRGs and the new DRGs 514 and 515 that were created for defibrillators, more homogenous in terms of patient characteristics and resource consumption.

Currently, the DRGs are generally ordered by MDC, which gives the DRGs a logical structure. Adding new DRGs sequentially at the end of the existing DRGs disturbs that order. However, because there is not a perfect solution to this problem, we will take the commenter's concerns into consideration as we proceed with future DRG revisions.

Longitudinal data analysis can be performed by mapping prior year's data with the current Medicare GROUPER. A conversion table is available for this purpose through the National Center for Health Statistics' website: *http://www.cdc.gov/nchs/icd9.htm* or may be purchased from the American Hospital Association (1–800–261–6246).

Comment: A commenter from a manufacturer of an implantable intracranial neurostimulator device used in the treatment of Parkinson's disease and essential tremor recommended that we revise the proposed revisions to DRGs 1 and 2 so that all deep brain stimulation procedures, such as intracranial neurostimulators for Parkinson's disease, are paid under proposed DRG 1. The commenter stated that, based on its review of FY 2000 MedPAR data,

approximately 75 percent of these cases would be assigned to proposed DRG 2 (and subject to an approximate 40-percent payment reduction under the proposed rule).

Response: Our proposed modification was based on FY 2001 MedPAR data. DRGs 1 and 2 included many different procedures with a range of costs associated with these procedures. Our analysis indicated a substantial cost differential between patients with CCs and patients without CCs, and the current DRGs 1 and 2 do not reflect this difference. We believe that the revision we proposed will improve the payment accuracy for cases in these DRGs. The prospective payment system is an average-based payment methodology under which losses that may be incurred for specific procedures or classes of patients are offset by payment gains from other procedures or classes of patients.

In our analysis, we found 847 cases in which an implantation of intracranial neurostimulator procedures was reported. The majority of these cases were being assigned to DRG 2 with average standardized charges of approximately $37,546. These charges are higher than the overall average standardized charges for all cases within DRG 2. However, this group of cases represents a small subset of all of the cases that are assigned to DRG 2. As noted above, we believe our proposed changes represent an overall improvement in payment accuracy for the over 40,000 cases assigned to these two DRGs.

Comment: Three commenters expressed concern with the proposed restructuring of DRGs 1 and 2 as it pertains to the open or endovascular treatment of ruptured or nonruptured aneurysms and arteriovenous malformation.

One commenter submitted data showing the average charges for ruptured aneurysm cases at $34,794 (and in some cases, $52,568), which are more than the average charges for DRG 1, and lengths of stay that are significantly higher than those for the proposed DRG 1. Another commenter assumed that treatment for ruptured aneurysms will remain in the revised DRG 1, and stated that our proposal to reduce the cost variance of these DRGs is a good beginning. However, according to the commenter, this proposed change does not go far enough because it will continue to underpay these extremely resource intensive cases. The commenter recommended that these cases be assigned to a different DRG (DRG 484 (Craniotomy for Multiple Significant Trauma) was suggested) or that a new DRG be created for these cases.

With respect to the treatment of nonruptured aneurysms, the commenters noted that we did not specify whether these cases would be assigned to DRG 1 or 2 and urged that these cases be assigned to DRG 1. The commenter noted that nonruptured interventional aneurysm cases are complex, and patients spend an average of 4.2 days in intensive care.

Response: In these cases, the patients' principal diagnosis would probably be the aneurysm. It is the secondary diagnosis or secondary condition that may be classified as a CC. Under the proposed changes, cases would be assigned to DRG 1 on the basis of a complication that occurred during the hospital stay or a comorbidity that existed at the time of admission or developed during the course of hospitalization. We found in our analysis that the majority of ruptured aneurysm cases and over half of craniotomy procedures in nonruptured aneurysm cases were being assigned to DRG 1, where charges for these cases were similar to the average for all cases in this DRG. The remaining nonruptured aneurysm cases were assigned to DRG 2 ($33,144 compared to $52,254). Our analysis did show the average standardized charges for the ruptured aneurysm to be $109,698, which is higher than the overall average charges of all cases within DRG 1. However, we point out, as noted by the commenter, these cases actually do receive higher payments under the changes we proposed.

Currently, DRG 484 includes complex, multiple significant trauma cases; that is, patients with a principal diagnosis of trauma and at least two significant trauma diagnosis codes (either as principal or secondaries) from different body site categories. While the intensity of treatment for aneurysms and arteriovenous malformations is significant, we do not believe aneurysm and arteriovenous malformation cases are clinically similar to other cases currently assigned to DRG 484.

Comment: One commenter stated that procedures involving implantation of a chemotherapeutic agent into the brain will be underpaid, causing hospitals to further limit use of this technology. The commenter provided data based on 24 patients being treated with this procedure and concluded that the hospital claims data did not reflect the true hospital cost for this product. The commenter stated that the average cost for this procedure is approximately $26,113. The commenter believed that these cases would be assigned to DRG 2 with an estimated payment of approximately $13,225.

Response: Procedure code 00.10 (Implantation of a chemotherapeutic agent) will be effective October 1, 2002, that will enable specific identification of these procedures. At this point, there are limited data available to assess the payment implications of our proposed change on this procedure. As noted above, cases that remain in DRG 1 would receive higher payments as a result of this change. Further, we would expect hospitals to generally be able to offset payment losses associated with a procedure that is used only rarely with payment gains associated with the higher payments for higher volume cases in DRG 1. Also, a low markup associated with one device or procedure is often offset by relatively higher markups associated with another device or procedure, leading to higher relative weights, and thus higher payments, for the latter device or procedure.

We believe that our proposal is appropriate according to currently available data. Therefore, we are adopting as final our proposal to redefine and retitle DRGs 1 and 2 as follows: DRG 1 (Craniotomy Age >17 with CC); and DRG 2 (Craniotomy Age >17 without CC).

b. Revisions of DRGs 14 and 15

To assess the appropriate classification of patients with stroke symptoms, we evaluated the assignment of cases to DRG 14 (Specific Cerebrovascular Disorders Except Transient Ischemic Attack (TIA) and DRG 15 (Transient Ischemic Attack and Precerebral Occlusions). Our data review indicated that the cases in DRGs 14 and 15 fell into three discrete groups. The first group included cases in which the patients were very sick, with severe intracranial lesions or subarachnoid hemorrhage and severe consequences. The second group included cases in which patients had not suffered a debilitating stroke but instead may have experienced a transient ischemic attack. The patients in the second group had one half of the average length of stay in the hospital as the first group. The third group of cases included patients who appeared to suffer strokes with minor consequences, as well as those having occluded vessels without having a full-blown stroke.

We found that patients who have intracranial hemorrhage and patients who have infarction are similar in severity. We proposed to continue to group patients with intracranial hemorrhage and infarction together. These types of cases are different from patients with, for example, an occlusive

carotid artery without infarction. In this latter group of cases, patients are not as severely ill because they typically have lesser degrees of functional status deficits.

Our analysis indicates that we can improve the clinical and resource cohesiveness of DRGs 14 and 15 by reassigning several specific ICD–9–CM codes. For example, code 436 (Acute, but ill-defined, cerebrovascular disease) is a non-specific code and contains patients with a wide range of deficits and anatomic problems. Our data show that these cases consume fewer resources and have shorter lengths of stay than other cases in DRG 14. Therefore, we proposed to remove code 436 from DRG 14 and reassign it to DRG 15. We also proposed to create a third new DRG that would help further differentiate cases currently assigned to DRGs 14 and 15. The proposed revised and new DRG titles were as follows: DRG 14 (Intracranial Hemorrhage and Stroke with Infarction); DRG 15 (Nonspecific Cerebrovascular Accident and Precerebral Occlusion without Infarction) (a corrected title from the one in the proposed rule); and DRG 524 (Transient Ischemia).

The following table represents a reconfiguration of DRGs 14 and 15 and the creation of a new DRG 524 reflecting these three categorizations (based on more recent data than that used in the proposed rule):

DRG and Title	Number of cases	Average length of stay (days)	Average charge
Revised DRG 14 (Intracranial Hemorrhage and Stroke with Infarction)	236,067	6.1	$15,643
Revised DRG 15 (Nonspecific Cerebrovascular Accident and Precerebral Occlusion without Infarction)	101,726	4.9	11,595
New DRG 524 (Transient Ischemia)	136,857	3.4	8,633

The reconfiguration of DRGs 14 and 15 results in the following codes being designated as principal diagnosis codes in revised DRG 14:

- 430, Subarachnoid hemorrhage.
- 431, Intracerebral hemorrhage.
- 432.0, Nontraumatic extradural hemorrhage.
- 432.1, Subdural hemorrhage.
- 432.9, Unspecified intracranial hemorrhage.
- 433.01, Occlusion and stenosis of basilar artery, with cerebral infarction.
- 433.11, Occlusion and stenosis of carotid artery, with cerebral infarction.
- 433.21, Occlusion and stenosis of vertebral artery, with cerebral infarction.
- 433.31, Occlusion and stenosis of multiple and bilateral arteries, with cerebral infarction.
- 433.81, Occlusion and stenosis of other specified precerebral artery, with cerebral infarction.
- 433.91, Occlusion and stenosis of unspecified precerebral artery, with cerebral infarction.
- 434.01, Cerebral thrombosis with cerebral infarction.
- 434.11, Cerebral embolism with cerebral infarction.
- 434.91, Cerebral artery occlusion, unspecified, with cerebral infarction.

We proposed that the following two codes be moved from DRG 14 to DRG 34 (Other Disorders of Nervous System with CC) and DRG 35 (Other Disorders of Nervous System without CC): Code 437.3 (Cerebral aneurysm, nonruptured) and Code 784.3 (Aphasia). These codes do not represent acute conditions. Aphasia, for example, could result from a cerebral infarction, but if it does, the infarction should be correctly coded as the principal diagnosis.

We proposed redefining DRG 15 so that it contains the following principal diagnosis codes:

- 433.00, Occlusion and stenosis of basilar artery, without mention of cerebral infarction.
- 433.10, Occlusion and stenosis of carotid artery, without mention of cerebral infarction.
- 433.20, Occlusion and stenosis of vertebral artery, without mention of cerebral infarction.
- 433.30, Occlusion and stenosis of multiple and bilateral arteries, without mention of cerebral infarction.
- 433.80, Occlusion and stenosis of other specified precerebral artery, without mention of cerebral infarction.
- 433.90, Occlusion and stenosis of unspecified precerebral artery, without mention of cerebral infarction.
- 434.00, Cerebral thrombosis without mention of cerebral infarction.
- 434.10, Cerebral embolism without mention of cerebral infarction.
- 434.90, Cerebral artery occlusion, unspecified, without mention of cerebral infarction.
- 436, Acute, but ill-defined, cerebrovascular disease.

We proposed to remove the following codes from the existing DRG 15 and place them in the proposed newly created DRG 524:

- 435.0, Basilar artery syndrome.
- 435.1, Vertebral artery syndrome.
- 435.2, Subclavian steal syndrome.
- 435.3, Vertebrobasilar artery syndrome.
- 435.8, Other specified transient cerebral ischemias.
- 435.9, Unspecified transient cerebral ischemia.

We proposed to move code 437.1 (Other generalized ischemic cerebrovascular disease) from DRG 16 (Nonspecific Cerebrovascular Disorders with CC) and DRG 17 (Nonspecific Cerebrovascular Disorders without CC) and add it to the proposed new DRG 524. This proposed change represented a modification to improve clinical coherence and seems to be a logical change for the construction of the proposed new DRG 524.

Comment: Several commenters opposed the movement of code 436 from DRG 14 into DRG 15. One commenter stated that the change is not supported in either the ICD–9–CM coding manual or the *Coding Clinic* for ICD–9–CM. The commenter noted that an inclusion note under code 436 identified this code as a diagnosis code for a stroke patient with cerebral infarctions. In addition, the commenter cited the *Coding Clinic,* Fourth Quarter, 1993 (pages 38 and 39), as including the term ''cerebral infarction'' following the term ''stroke'', which indicated to the commenter that these terms are synonymous. The commenter recommended that, prior to making any changes, CMS work with the ICD–9–CM Coordination and Maintenance Committee to revise the ICD–9–CM tabular section to correct this inconsistency.

Response: We agree with the commenter that the ICD–9–CM code 436 does, in fact, describe a stroke. However, the code is nonspecific as to the nature of a stroke. In addition, data on cases containing code 436 that were reported in our MedPAR file indicated that these types of cases have a shorter length of stay and lower hospital charges associated with them. Our revised title of DRG 15 reflects our recognition of code 436 as describing a stroke; that is, we are changing the title of DRG 15 to ''Nonspecific Cerebrovascular Accident and Precerebral Occlusion without Infarction.'' With regard to the revision

of the ICD–9–CM diagnosis tabular section describing code 436, we understand that the National Center for Health Statistics (NCHS) plans to address this issue at the December 4th and 5th, 2003 meeting of the ICD–9–CM Coordination and Maintenance Committee. While we agree with NCHS' plan to examine this issue, we are not delaying these DRG changes while waiting for modifications to this section of the coding manual.

Comment: Two commenters opposed any changes in DRGs 14 and 15 until better data become available. One of these commenters noted that moving approximately 80,000 cases from a higher paying DRG to a lower paying DRG will significantly impact many hospital's financial status.

Both commenters opposed moving code 436 from DRG 14 into DRG 15, noting that code 436 is a common code for stroke or cerebrovascular accident when the physician does not specify whether the stroke is an intracranial hemorrhage or cerebral infarction. The commenters noted that performance of diagnostic imaging may add specificity to determine which artery was involved, thus allowing more specific coding to occur. However, it may not change the course of treatment for the stroke. In addition, the commenters stated that, in some cases, it is ill-advised to subject the patient to further testing to make this determination. Further, in some cases, the tests may be inconclusive but in most cases the course of treatment would not be changed.

One commenter indicated that there is probably inconsistency among coders in the use of the more specific 5-digit codes for ''with cerebral infarction'' for categories 433 (Occlusion and stenosis of precerebral arteries) and 434 (Occlusion of cerebral arteries) due to variable interpretations of coding instructions. The commenter noted that there are currently efforts to provide clarification regarding the proper use of these 5-digit codes.

Response: We recognize that some of the diagnostic codes in section 430 through 437 of ICD–9–CM may be more specific than the diagnostic documentation in the medical record, which may make it difficult to precisely code cerebrovascular disease. We also recognize that code 436 may be a catchall code when more specific information on the patient's condition is not available in the record. Further, it is possible that other less severe cases are being labeled ''stroke,'' absent more thorough testing or workup. However, our proposed changes to DRGs 14 and 15 were based on actual MedPAR data from FY 2001. As demonstrated above, there is a clear demarcation between average charges and lengths of stay across the two revised DRGs and one new DRG. Further, payment for many cases is higher after these changes than it was previously. For FY 2003, the DRG relative weights for DRGs 14 and 15 were 1.1655 and 0.7349, respectively. The proposed FY 2003 relative weights for DRGs 14, 15 and 524 were 1.2742, 0.9844, and 0.7236. Therefore, cases remaining in DRG 14 would receive higher payments as a result of moving less expensive cases into DRG 15 or 524. Similarly, cases remaining in DRG 15 would receive much higher payments than they had previously.

We believe these changes improve the clinical and resource cohesiveness of the DRGs for these cases. We acknowledge the concerns expressed by the commenters that code 436 may frequently be used in lieu of more specific codes that require further tests even though the cases are as severely ill as those with more specific diagnosis indicated on the bill. However, this is not borne out by the data.

To the prospect of more available data in the future, we note that changes to codes in the related section of the ICD–9–CM coding book have been in place since 1993. We believe that 9 years is sufficient time to clarify the coding issues and to adequately train both the coding and medical staffs regarding documentation of cerebrovascular disease.

Comment: One commenter opposed the movement of code 437.1 to new DRG 524, noting that conditions classified to this code are generally chronic or long term in nature, not transient.

Response: The titles of DRGs are not intended to uniquely identify each case within the DRG, but to logically group cases that globally have similar characteristics in terms of clinical requirements and resources utilized. We proposed the movement of code 437.1 from DRGs 16 and 17 in order to improve the clinical coherence of DRGs 16 and 17, and the new DRG 524; we believe this change accomplishes that. Therefore, we are adopting the proposed change as final.

Comment: One commenter supported the movement of codes 437.3 and 784.3 from DRG 14 to DRGs 34 and 35.

Response: We appreciate the commenter's support. Accordingly, we are adopting the proposed change to move codes 437.3 and 784.3 to DRGs 34 and 35, as final.

We are adopting as final the proposed changes to DRGs 14 and 15 and the creation of new DRG 524 without modifications. We will continue to monitor these DRGs for shifts in resource consumption and validity of DRG assignment and will specifically monitor code 436 for appropriate placement in DRG 15. We support the concept of clarification of the coding guidelines in this section of ICD–9–CM and will also monitor these DRGs when the guidelines are updated.

3. MDC 5 (Diseases and Disorders of the Circulatory System)

a. Heart Assist Systems

Heart failure is typically caused by persistent high blood pressure (hypertension), heart attack, valve disease, other forms of heart disease, or birth defects. It is a chronic condition in which the lower chambers of the heart (ventricles) cannot pump sufficient amounts of blood to the body. This causes the organs of the body to progressively fail, resulting in numerous medical complications and frequently death. DRG 127 (Heart Failure and Shock), to which heart failure cases are assigned, is the single most common DRG in the Medicare population, and represents the medical, not surgical, treatment options for this group of patients.

In many cases, heart transplantation would be the treatment of choice. However, the low number of donor hearts limits this treatment option. Circulatory support devices, also known as heart assist systems or left ventricular assist devices (LVADs), offer a surgical alternative for end-stage heart failure patients. This type of device is often implanted near a patient's native heart and assumes the pumping function of the weakened heart's left ventricle. Studies are currently underway to evaluate LVADs as permanent support for end-stage heart failure patients.

We have reviewed the payment and DRG assignment of this type of device in the past. Originally, these cases were assigned to DRG 110 (Major Cardiovascular Procedures with CC) and DRG 111 (Major Cardiovascular Procedures without CC) in the September 1, 1994 final rule (59 FR 45345). A more specific procedure code, 37.66 (Implant of an implantable, pulsatile heart assist system) was made effective for use with hospital discharges occurring on or after October 1, 1995. In the August 29, 1997 final rule (62 FR 45973), we reassigned these cases to DRG 108 (Other Cardiothoracic Procedures), because it was the most clinically similar DRG with the best match in resource consumption according to our data. In the July 31, 1998 final rule (63 FR 40956), we again reviewed our data and discovered that

the charges for implantation of an LVAD were increasing at a greater rate than the average charges for DRG 108. The length of stay for cases with code 37.66 was approximately 32 days, or three times as long as all other DRG 108 cases. Therefore, we decided to move LVAD cases from DRG 108 to DRG 104 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization) and DRG 105 (Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization). We continued to review our data and discuss this topic in the FY 1999 and FY 2000 annual final rules: July 30, 1999 (64 FR 41498) and August 1, 2000 (65 FR 47058).

In the August 1, 2001 final rule (66 FR 39838), we remodeled MDC 5 to add five new DRGs. We also added procedure codes 37.62 (Implant of other heart assist system), 37.63 (Replacement and repair of heart assist system), and 37.65 (Implant of an external, pulsatile heart assist system) to DRGs 104 and 105. We removed defibrillator cases from DRGs 104 and 105 and assigned them to DRG 514 (Cardiac Defibrillator Implant with Cardiac Catheterization) and DRG 515 (Cardiac Defibrillator Implant without Cardiac Catheterization) to make these DRGs more clinically coherent. This also increased the relative weights for DRGs 104 and 105, as the defibrillator cases had lower average charges than other cases in those two DRGs.

In the FY 2001 MedPAR data file, we found 185 LVAD cases in DRG 104 and 90 cases in DRG 105, for a total of 275 cases. These cases represent 1.3 percent of the total cases in DRG 104, and approximately 0.5 percent of the total cases in DRG 105. However, the average charges for these cases are approximately $36,000 and $85,000 higher than the average charges for cases in DRGs 104 and 105, respectively.

This situation presents a dilemma, in that the technology has been available since 1995 and is gradually increasing in utilization, while LVAD cases remain a small part of the total cases in these two DRGs. In fact, removing LVAD cases from the calculation of the average charge changes the average by only −0.4 percent and −0.5 percent for DRGs 104 and 105, respectively. Therefore, despite the dramatically higher average charges for LVADs compared to the DRG averages, the relative volume is insufficient to affect the DRG average charges to any great degree.

Therefore, we proposed to create a new DRG 525 (Heart Assist System Implant), which would contain these cases. The FY 2003 relative weight for the new DRG 525 is 11.6479.

As discussed below, the comments we received supported this change. Therefore, we are creating new DRG 525, which consists of any principal diagnosis in MDC 5, plus one of the following surgical procedures:

- 37.62, Implant of other heart assist system
- 37.63, Replacement and repair of heart assist system
- 37.65, Implant of an external, pulsatile heart assist system
- 37.66, Implant of an implantable, pulsatile heart assist system

Cases in which a subsequent heart transplant occurs during the hospitalization episode will continue to be assigned to DRG 103 (Heart Transplant) because cases involving procedure codes 336 (Combined heart/lung transplant) and 375 (Heart transplant) are assigned to DRG 103, regardless of other codes included on the bill.

We reiterate a discussion we included in the August 1, 2000 final rule (65 FR 47058) regarding placement of code 37.66 in the MCE screening software as a noncovered procedure. The default designation for that code will continue to be ''noncovered'' because of the stringent conditions that must be met by hospitals in order to receive payment for implantation of the device.

Section 65–15 of the Medicare Coverage Issues Manual (Artificial Hearts and Relative Devices) provides the national coverage determination regarding Medicare coverage of these devices. This section may be accessed online at *www.hcfa.gov/pubforms/06_cim/ci00.htm.*

Comment: Several commenters supported the proposed creation of a new DRG 525 for patients receiving implanted heart assist systems. One commenter stated that the creation of a new DRG 525 would be more sensitive to the patient population, more accurate in statistical analysis and data reports, and more responsive to changes in LVAD charges and utilization patterns.

Other commenters suggested that the payment amount still understates the reasonable cost of LVAD implantation. One commenter provided analysis that purported to show that the net payment effect of this change is insignificant due to the increase in the outlier threshold as discussed in the proposed rule (and in the Addendum to this final rule). Another commenter stated that this new DRG results in payment that does not even compensate for the costs to the hospital of the device itself. The commenter noted that current payment levels for LVADs do not take into account the equipment required for discharge, that is, both disposable and durable medical equipment.

Some of the commenters recommended that we consider allowing LVADs to qualify for a new technology add-on payment in addition to establishing a new DRG specific to this technology.

Response: Regarding the commenter's analysis of the net payment effect of the proposed new DRG 525, the increase in the outlier threshold is not related to the creation of the new DRG 525. As discussed in detail in the Addendum, the FY 2002 outlier threshold was set at a point that resulted in excessive outlier payments. The commenter's analysis compared payments if these cases remained in DRGs 104 and 105 and received outlier payments in accordance with the lower FY 2002 outlier threshold to payments under the new DRG 525 using the proposed outlier threshold. Therefore, the commenter's analysis does not accurately represent payments under the DRGs. The correct analysis is to compare payments under DRGs 104 and 105 with payments under the new DRG 525, absent outlier payments, which results in an increase in payments of over 40 percent per case. Since cases qualify for outlier payments on the basis of a constant fixed-dollar loss threshold and receive payments equal to 80 percent of costs above the threshold, the 40-percent differential in payments is not affected by outlier payments.

With regard to the commenters' indication that the payment under the new DRG 525 is insufficient, we note that the DRG relative weights are based on charge data for actual LVAD cases in the Medicare discharge database, using the most recent information available (the FY 2001 MedPAR file). (Section II.C. of this final rule contains a complete discussion of this methodology.)

With regard to the commenter's suggestion that LVADs be eligible for add-on payments for new technology, we point out that our criteria require that the mean charges of the cases involving a new technology exceed a threshold of one standard deviation beyond the mean charge for all cases in the DRG. Since DRG 525 is specific to heart assist systems, the mean charge of the cases involving the new technology is the same as the mean charge for all cases in the DRG. Also, this technology does not meet our criteria to be considered new (see discussion at section II.D. below).

Finally, with regard to the concept that the DRG payment for LVAD should take into account disposable and

durable medical equipment after discharge, we point out that the Medicare Part A inpatient hospital payment is distinct from the Medicare Part B outpatient payments.

Comment: One commenter stated if LVAD implantation is approved for patients who are not heart transplant patients, the payment is likely to still be too low, as it is anticipated that these patients comprise a generally sicker population. The commenter suggested that we direct hospitals to bill uniformly for LVAD devices via the designated ICD–9–CM procedure codes that will classify into DRG 525.

Response: As we noted in the proposed rule, we understand that studies are currently underway to evaluate LVADs as permanent support for end-stage heart failure patients. However, at this time, these applications are only on a trial basis. Further, in the absence of specific data demonstrating additional costs associated with expanded uses of LVADs beyond bridge-to-transplant patients, we do not take anticipated higher costs into account in the DRG relative weight calculation. However, we will continue to monitor new DRG 525 as new developments occur in the approved uses of LVAD technology to ensure appropriate classification and payment of these cases.

With respect to the comment that we should provide further guidance on the correct ICD–9–CM coding procedures for LVADs, as explained above and in the proposed rule, cases with any principal diagnosis in MDC 5 reporting code 37.62, 37.63, 37.65, or 37.66 will be assigned to DRG 525 (in the absence of a transplant). Further information regarding the use of these codes may be obtained by referring to a relevant article from the *Coding Clinic,* Fourth Quarter, 1995 (pages 68 and 69).

Comment: One commenter, while approving the movement of codes 37.63, 37.65, and 37.66 to DRG 525, did not believe that cases with code 37.62 belong in this DRG. The commenter stated that code 37.62 includes centrifugal pumps, heart assist systems that are not specified as pulsatile, and the insertion of not otherwise specified heart assist systems, and urged CMS to reconsider inclusion of this code in the new DRG. The commenter stated that centrifugal pumps are more similar to cardiac bypass procedures than to ventricular assist systems, and inclusion of this code would likely reduce the relative weight of DRG 525 due to the lower cost of this type of technology. The commenter recommended that code 37.62 remain in DRG 104 and 105. The commenter was also concerned that the change would create a potential incentive for these technologies to be used for purposes not yet approved by the FDA.

Response: Our analysis indicates that these four codes represent the most expensive cases in MDC 5, aside from heart transplantation in DRG 103, which is the reason we moved them out of DRGs 104 and 105. However, we will continue to evaluate the appropriate assignment of cases into this new DRG, particularly if new uses for heart assist systems are approved by the FDA, and will take the commenter's recommendation into account when we conduct our annual MedPAR review next year.

Comment: One commenter suggested that we develop a new heart transplant DRG entitled ''Heart Transplant with LVAD,'' because the costs of the LVADs have not been incorporated into the heart transplant DRG. The commenter stated that, since a great number of LVAD cases remain inpatients until heart transplant occurs, there is a disparity in costs between heart transplant patients who receive LVADs during the stay, and those who do not remain inpatients.

Response: As we pointed out above, cases in which a subsequent heart transplant occurs during the hospitalization episodes are currently assigned to DRG 103 (Heart Transplant) because cases involving procedure codes 33.6 (Combined heart/lung transplant) and 37.5 (Heart transplant) are assigned to DRG 103, regardless of other codes included on the bill. We believe these cases are appropriately compensated in these DRGs, but we will continue to monitor this issue in the future.

Comment: One commenter requested that we review our data to determine if there is an incorrect mix of devices being included in the calculation of the DRG weight. The commenter suggested that perhaps that there is some inappropriate mixing of data, and that there are temporary assist devices used in the intensive care unit (ICU) that are quite distinct from those used for longer term bridge-to-transplant. This commenter noted that these ICU devices are much less expensive.

Response: As noted in the proposed rule, average length of stay and charge data were calculated for all cases including codes 37.62, 37.63, 37.65, and 37.66. These codes describe the implantation of heart assist systems, which is the construct of the new DRG 525. Therefore, we believe we have appropriately accounted for these cases in our analysis.

Comment: One commenter expressed concern that we did not separate payment for LVADs used in the acute care setting from LVADs used as chronic care devices, and pointed out that the short-term indication uses only a fraction of the resources required for a chronic or long-term LVAD. The commenter asked us to consider two DRGs, one for acute care devices and one for long-term care devices, that better reflect the resource consumption of each indication.

Response: The LVAD is currently being studied as a device that would support end-stage heart failure patients in the absence of a heart transplant. This use is not out of the clinical trial phase and, more importantly, has not been recognized as a Medicare covered service. It would be premature to establish a DRG based on the possibility that the LVAD may some day be approved for this indication is premature.

b. Moving Diagnosis Code 398.91 (Rheumatic Heart Failure) From DRG 125 to DRG 124

DRG 124 (Circulatory Disorders Except Acute Myocardial Infarction (AMI), with Cardiac Catheterization and Complex Diagnosis) and DRG 125 (Circulatory Disorders Except Acute Myocardial Infarction (AMI) with Cardiac Catheterization without Complex Diagnosis) have a somewhat complex DRG logic. In order to be assigned to DRG 124 or 125, the patient must first have a circulatory disorder, which would be one of the diagnoses included in MDC 5. However, these DRGs exclude acute myocardial infarctions. Therefore, these DRGs are comprised of cases with a diagnosis from MDC 5, excluding acute myocardial infarction, but also with a cardiac catheterization during the stay.

DRGs 124 and 125 are then further defined by whether or not the patient had a complex diagnosis. If the patient has a complex diagnosis, the case is assigned to DRG 124. If the patient does not have a complex diagnosis, the case is assigned to DRG 125. A list of diagnoses that comprise complex diagnoses is identified within DRG 124. These diagnoses can be listed as either a principal or secondary diagnosis.

We have received correspondence regarding the current assignment of diagnosis code 398.91 (Rheumatic heart failure). The correspondent pointed out that, while other forms of heart failure are listed as complex diagnoses under DRG 124, rheumatic heart failure is not included as a complex diagnosis within that DRG. Currently, if a patient with rheumatic heart failure receives a

cardiac catheterization, the case is assigned to DRG 125.

The correspondent had conducted a study and found that patients with rheumatic heart failure who receive a cardiac catheterization have lengths of stay that are significantly longer than patients with other forms of heart failure who receive a cardiac catheterization and who are assigned to DRG 125. The correspondent found that these patients have lengths of stay more similar to those cases assigned to DRG 124 (which have other forms of heart failure), and recommended that diagnosis code 398.91 be added to the list of complex diagnoses within DRG 124.

Within our claims data, we found 439 cases of patients in DRG 125 with rheumatic heart failure that received a cardiac catheterization. The average charges for these rheumatic heart failure cases were almost twice as much as for other cardiac patients in DRG 125 who received a cardiac catheterization and who did not have a diagnosis of rheumatic heart failure. We also conferred with our medical consultants and they agree that rheumatic heart failure with cardiac catheterization is a complex diagnosis and should be assigned to DRG 124 along with the other complex forms of heart failure cases involving cardiac catheterization.

We proposed to add code 398.91 to DRG 124 as a complex diagnosis. As a result, catheterization cases with rheumatic heart disease would no longer be assigned to DRG 125.

Several commenters representing hospitals and medical coders supported our proposal to classify code 398.91 as a complex diagnosis within DRG 124, which moves these cases from DRG 125. Accordingly, we are adopting as final the proposed change.

c. Radioactive Element Implant

In the August 1, 2001 final rule, we created DRG 517 (Percutaneous Cardiovascular Procedure without Acute Myocardial Infarction (AMI) with Coronary Artery Stent Implant) as a result of the overall DRG splits based on the presence of AMI (66 FR 39839). We assigned code 92.27 (Implantation or insertion of radioactive elements) to DRG 517 because we believed that code 92.27 would always accompany cases involving a percutaneous cardiovascular procedure and intravascular radiation treatment.

We have since determined that code 92.27 can also be present as a stand-alone code in other types of cases. When cases with an MDC principal diagnosis and code 92.27 do not meet the criteria for assignment to DRG 517 because there is no indication of a percutaneous cardiovascular procedure, they are currently assigned to DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis). Because DRG 468 is reserved for cases in which the O.R. procedure is unrelated to the principal diagnosis, we proposed to assign cases with code 92.27 that do not meet the criteria for assignment to DRG 517, but that would otherwise be assigned to MDC 5, to DRG 120 (Other Circulatory System O.R. Procedures).

Comment: One commenter supported the proposal. Another commenter was unclear why code 92.27 is designated as an operating room procedure and would be assigned to DRG 120 (Other Circulatory System O.R. Procedures) if reported as a stand-alone procedure. This commenter stated that it is not aware of instances when it is appropriate to report this code without a concomitant cardiovascular procedure, and believed that another procedure, such as angioplasty, is needed in order to insert the radioactive implants. The commenter believed that cases in which code 92.27 was reported by itself for treatment of a cardiovascular disorder may represent incorrect coding.

Response: We proposed this modification to MDC 5 (Diseases and Disorders of the Circulatory System), concerning the assignment of code 92.27 (when reported as the only procedure) to DRG 120 in part, as a result of a telephone call from a member of the general public. The inquirer questioned the assignment of code 92.27 without angioplasty and with a principal diagnosis in MDC 5 to DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis). When we created DRG 517 in the FY 2002 final rule, we also did not consider that a radioactive implant would be inserted without angioplasty as a delivery technique. We were advised by our medical advisors that it could occur, but it was unlikely. Code 92.27 has not yet been reported in our MedPAR data in MDC 5 as a stand-alone procedure. However, to address the possibility that it might be reported alone, we are taking this opportunity to assign code 92.27 to DRG 120 in MDC 5, consistent with the principal diagnosis, instead of a (higher-weighted) DRG in which the principal diagnosis and the procedure do not match (DRG 468).

With regard to the commenter's question about the designation of code 92.27 as an operating room procedure, we note that code 92.27 has always been considered by the Medicare GROUPER to be a procedure code affecting DRG assignment. It can be found in 12 MDCs and 20 DRGs in GROUPER version 19.0.

Comment: One commenter commended us for responding to its previously submitted comments concerning inadequate DRG payment for GP IIb–IIIa platelet inhibitors, but noted that its request from last year was not mentioned in our proposed rule in our review of several cardiovascular DRGs for both interventional and medical cases that receive GP IIb–IIIa inhibitors. The commenter stated that without a review of the presence of code 99.20 (Injection or infusion of platelet inhibitor) in DRGs 124 (Circulatory Disorders Except AMI, with Cardiac Catheterization and Complex Diagnosis) and 140 (Angina Pectoris), CMS cannot be certain that a significant number of cases are not significantly underpaid.

Response: We regret this omission in the proposed rule. We did, in fact review both DRGs 124 and 140 for the presence of code 99.20. In DRG 124, there were a total of 95,452 cases without code 99.20. These cases had an average length of stay of 4.4 days and average charges of $17,594. There were 1,120 cases in DRG 124 with code 99.20.

These cases had an average length of stay of 3.5 days, and average charges of $17,256. In DRG 140, there were a total of 45,886 cases without code 99.20, with an average length of stay of 2.5 days and average charges of $6,204. There were 126 cases in DRG 140 with code 99.20, with an average length of stay of 2.3 days, and average charges of $8,675.

The data do not demonstrate a level of disparity in days and charges that would warrant an adjustment to these DRGs based on the presence of code 99.20. Therefore, we are not making any changes concerning the status of code 99.20 in these DRGs for FY 2003.

4. MDC 10 (Endocrine, Nutritional, and Metabolic Diseases and Disorders)

Currently, when ICD–9–CM code 277.00 (Cystic Fibrosis without mention of meconium ileus) is reported as the principal diagnosis, it is assigned to the following DRG series in MDC 10: DRG 296 (Nutritional and Metabolic Disease, Age >17 with CC); DRG 297 (Nutritional and Metabolic Disease, Age >17 without CC); and DRG 298 (Nutritional and Metabolic Disease, Age 0–17).

As part of our annual review of DRG assignments and based on correspondence that we have received, we examined cases involving code 277.00 as a principal diagnosis in DRGs 296, 297, and 298. Our analysis of the average charges for these cases indicates that resource utilization for these cases is quite different from resource utilization for other cases in these three DRGs. We believe that this difference in resource utilization is due to the fact it

is not uncommon for cystic fibrosis patients to be admitted with pulmonary complications. Our findings on the number of cases and the average charges in the three DRGs when code 277.00 is assigned as the principal diagnosis, and our findings for all cases in the three DRGs, are indicated in the charts below.

CASES IN DRG, 296, 297, AND 298 WITH CODE 277.00 AS THE PRINCIPAL DIAGNOSIS

DRG and description	Number of cases	Average charges
DRG 296 (Nutritional & Metabolic Disease Age >17 with CC)	271	$34,111
DRG 297 (Nutritional & Metabolic Disease Age >17 without CC)	133	21,998
DRG 298 (Nutritional & Metabolic Disease Age 0–17)	0	.....

ALL CASES IN DRG 296, 297, 298

DRG 298 description	Number of cases	Average charges
DRG 296 (Nutritional & Metabolic Disease Age >17 with CC)	169,768	$10,480
DRG 297 (Nutritional & Metabolic Disease Age >17 without CC)	31,560	6,190
DRG 298 (Nutritional & Metabolic Disease Age 0–;17)	17	8,603

Based on the results of our analysis, we proposed that three new cystic fibrosis principal diagnosis codes be assigned to specific DRGs and MDCs, and that other changes be made to DRG and MDC assignments of existing cystic fibrosis codes, as discussed below.

We proposed to use the following three new principal diagnosis codes to further inform DRG assignment of these patients:

- 277.02 (Cystic fibrosis with pulmonary manifestations)
- 277.03 (Cystic fibrosis with gastrointestinal manifestations)
- 277.09 (Cystic fibrosis with other manifestations)

We proposed that existing code 277.01 (Cystic fibrosis with mention of meconium ileus) would continue to be assigned to DRG 387 (Prematurity with Major Problems) and DRG 389 (Full Term Neonate with Major Problems) in MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period), since it is a newborn diagnosis code.

Because the new code 277.02 would identify those patients with cystic fibrosis who have pulmonary manifestations, we proposed to assign cases in which this is the principal diagnosis to DRG 79 (Respiratory Infection and Inflammations Age >17 with CC), DRG 80 (Respiratory Infections and Inflammations Age >17 without CC), or DRG 81 (Respiratory Infections and Inflammations Age 0–17) in MDC 4 (Diseases and Disorders of the Respiratory System).

We proposed that the new code 277.03 would be assigned to DRG 188 (Other Digestive System Diagnoses Age >17 with CC), DRG 189 (Other Digestive System Diagnoses Age >17 without CC), and DRG 190 (Other Digestive System Diagnoses Age 0–17) in MDC 6 (Diseases and Disorders of the Digestive System), because of its specific relationship to the digestive system.

Since the new code 277.09 could involve a number of manifestations (excluding pulmonary and gastrointestinal), we proposed to assign this new code to DRGs 296, 297, and 298 in MDC 10, where we are retaining the current assignment of existing code 277.00.

The following chart summarizes our proposed DRG and MDC assignments for new and existing cystic fibrosis principal diagnosis codes:

Principal diagnosis code and description	MDC assignment	DRG assignments
Existing 277.00 (Cystic fibrosis without mention of meconium ileus)	10	296, 297, 298
Existing 277.01 (Cystic fibrosis with mention of meconium ileus)	15	387, 389
New 277.02 (Cystic fibrosis with pulmonary manifestations)	4	79, 80, 81
New 277.03 (Cystic fibrosis with gastrointestinal manifestations)	6	188, 189, 190
New 277.09 (Cystic fibrosis with other manifestations)	10	296, 297, 298

Several commenters representing hospitals, medical coders, and specialty groups supported the proposed DRG assignments relating to cystic fibrosis discussed above. Therefore, we are adopting the proposed DRG assignments as final, effective for discharges occurring on or after October 1, 2002.

5. MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract)

a. Insertion of Totally Implantable Vascular Access Device (VAD)

In the August 1, 2001 final rule (66 FR 39844), we discussed our review of the DRG assignment of code 86.07 (Insertion of totally implantable vascular access device (VAD)). Code 86.07 is considered a nonoperative procedure when it occurs in MDC 11. In other words, the Medicare GROUPER software program does not recognize code 86.07 as a procedure code when reported with any principal diagnosis in this MDC. Therefore, patients in renal (kidney) failure requiring implantation of this device for dialysis are grouped to medical DRG 316 (Renal Failure). We examined whether implantation of this device should be removed from DRG 316 and placed into surgical DRG 315 (Other Kidney and Urinary Tract O.R. Procedures).

Implantation of a VAD into the chest wall and blood vessels of a patient's upper body allows access to a patient's vessels via an implanted valve and cannula. Two devices are implanted during one operative session. One system is implanted arterially (the ''draw''), while the other is implanted venous (the ''return''). Typically, the VAD allows access to the patient's blood for hemodialysis purposes when other sites in the body have been exhausted. The device is usually inserted in the outpatient setting. Operative time is approximately 1 to 1.5 hours.

In the FY 2002 final rule (66 FR 39844–39845), we pointed out that cases where the VAD was inserted as an inpatient procedure often involved complications, leading to higher average charges and longer lengths of stay for those cases. Therefore, we indicated that we would not assign code 86.07 to DRG 315 at that time, but we would consider other alternative adjustments to DRGs 315 and 316.

For FY 2003, we explored whether DRG 315 should be divided based on the presence or absence of CCs. However, during our consideration of this alternative, we discovered that DRG 315 does not lend itself to a CC split due to the high occurrence of cases in this DRG that already have complications identified on the CC list. Therefore, we

reexamined cases in DRGs 315 and 316 in the FY 2001 MedPAR file. The results are reflected in the chart below:

	With code 86.07	Without code 86.07
DRG 315 (Surgical):		
Number of Cases	354	21,089
Average Length of Stay.	12.6 days.	6.7 days
Average Charges	$47,251	$25,622
DRG 316 (Medical):		
Number of Cases	887	76,676
Average Length of Stay.	10.3	6.6 days
Average Charges	$31,904	$16,934

These results are similar to the findings included in the FY 2002 final rule that were based on data from the FY 2000 MedPAR file (66 FR 39845).

We found that the average length of stay in DRG 315 for patients not receiving the VAD is 6.7 days, while those patients who received the VAD had an average length of stay of 12.6 days. We found the average charges in DRG 315 for patients not receiving the VAD were approximately $25,622, while the average charges for those patients who received the VAD were $47,251.

We found that the cases receiving the VAD as an inpatient procedure are significantly more costly than other cases in DRG 316. Therefore, we proposed to designate code 86.07 as an O.R. procedure under MDC 11.

Specifically, code 86.07 will be recognized as an O.R. procedure code in MDC 11 and assigned to DRG 315 when combined with the following principal diagnosis codes from DRG 316:

- 403.01, Malignant hypertensive renal disease with renal failure
- 403.11, Benign hypertensive renal disease with renal failure
- 403.91, Unspecified hypertensive renal disease with renal failure
- 404.02, Malignant hypertensive heart and renal disease with renal failure
- 404.12, Malignant hypertensive heart and renal disease with renal failure
- 404.92, Unspecified hypertensive heart and renal disease with renal failure
- 584.5, Acute renal failure with lesion of tubular necrosis
- 584.6, Acute renal failure with lesion of renal cortical necrosis
- 584.7, Acute renal failure with lesion of renal medullary (papillary) necrosis
- 584.8, Acute renal failure with other specified pathological lesion in kidney
- 584.9, Acute renal failure, unspecified
- 585, Chronic renal failure
- 586, Renal failure, unspecified
- 788.5, Oliguria and anuria
- 958.5, Traumatic anuria

We received two comments in support of this proposal. Therefore, we are adopting as final the proposed redesignation of code 87.06 as an O.R. procedure under MDC 11 and its assignment to DRG 315 when combined with the principal diagnosis codes from DRG 316 listed above.

b. Bladder Reconstruction

We received correspondence regarding the current classification of procedure code 57.87 (Reconstruction of urinary bladder) as a minor bladder procedure and the assignment of the code under DRG 308 (Minor Bladder Procedures with CC) and DRG 309 (Minor Bladder Procedures without CC). The correspondent believed that bladder reconstruction is not a minor procedure, submitted individual hospital charges to support this contention, and recommended that the code be classified as a major procedure and assigned to a higher weighted DRG.

Our clinical advisors indicated that reconstruction of the bladder is a more extensive procedure than the other minor bladder procedures in DRGs 308 and 309. They agree that the bladder reconstruction procedure is as complex as the procedures under code 57.79 (Total cystectomy) and the other major bladder procedures in DRGs 303 through 305.

As indicated in the chart below, we found that the average charges for bladder reconstruction are significantly higher than the average charges for other minor procedures within DRGs 308 and 309:

	With code 57.87	Without code 57.87
DRG 308 (Minor Bladder Procedure with CC):		
Number of Cases	64	5,066
Average Charges	$36,560	$19,923
DRG 309 (Minor Bladder Procedures without CC):		
Number of Cases	25	3,021
Average Charges	$23,390	$11,200

We found that procedure code 57.87 may be more appropriately placed in DRG 303 (Kidney, Ureter and Major Bladder Procedures for Neoplasm), 304 (Kidney, Ureter and Major Bladder Procedures for Nonneoplasm with CC), and DRG 305 (Kidney, Ureter and Major Bladder Procedures for Nonneoplasm without CC), based on average charges for procedures in these three DRGS as indicated in the following chart:

DRG	Number of cases	Average charges
303 (Kidney, Ureter and Major Bladder Procedures for Neoplasm)	14,116	$30,691
304 (Kidney, Ureter and Major Bladder Procedures for Nonneoplasm with CC)	8,060	30,577
305 (Kidney, Ureter and Major Bladder Procedures for Nonneoplasm without CC)	2,029	15,492

Based on the results of our analysis and the advice of our medical consultants discussed above, we proposed to classify code 57.87 as a major bladder procedure and to assign it to DRGs 303, 304, and 305.

We received several comments from associations representing hospitals and medical coders in support of the proposed reclassification of bladder reconstruction surgery from a minor bladder to a major bladder procedure. Accordingly, we are adopting as final the proposed reclassification, effective for discharges occurring on or after October 1, 2002.

6. MDC 15 (Newborns and Other Neonates With Conditions Originating in the Perinatal Period)

The primary focus of updates to the Medicare DRG classification system is for changes relating to the Medicare patient population, not the pediatric or neonatal patient populations. However, the Medicare DRGs are sometimes used to classify other patient populations. Over the years, we have received comments about aspects of the Medicare newborn DRGs that appear problematic, and we have responded to these on an individual basis. Some correspondents have requested that we take a closer overall look at the DRGs within MDC 15.

Because of our limited data and experience with newborn cases under Medicare, we contacted the National Association of Children's Hospitals and Related Institutions (NACHRI), along with our own medical advisors, to obtain proposals for possible revisions of the existing DRG categories in MDC 15. The focus of the requested proposals was to refine category definitions within the framework of the existing seven broadly defined neonatal DRGs. The proposals also were to take advantage of the new, more specific neonatal

diagnosis codes to be adopted, effective October 1, 2002, to assist with refinements to the existing DRG category definitions.

In the May 9, 2002 proposed rule, we proposed to make extensive changes to multiple DRG categories in MDC 15. A complete description of these proposed changes appears in the May 9, 2002 **Federal Register** at 67 FR 31412 through 31414. In summary, the proposed changes involved removing a number of congenital anomalies from MDC 15 and assigning them to other MDCs. NACHRI advised us that these congenital anomalies would be better classified in the MDC for the body system affected. We also proposed revising DRG 386 (Extreme Immaturity or Respiratory Distress Syndrome, Neonate), to refine the assignment of newborn cases diagnosed with extreme immaturity. We proposed major revisions for DRG 387 (Prematurity With Major Problems) to redefine the codes for prematurity and the codes that define a ''major problem''. We proposed modifications of DRG 388 (Prematurity Without Problems), which involved changes in the classification of prematurity for newborns. We proposed revising the definition of a ''major problem'' for DRG 389 (Full Term Neonate With Major Problem) as well. By changing the definition of ''major problem'' in the other DRGs, our proposal would have increased the number of cases being assigned to DRG 390. Finally, we proposed to expand the number of minor problem newborn diagnoses included in DRG 391 (Normal Newborn). All of these extensive changes would have greatly shifted the DRG assignments for newborns, involving hundreds of ICD–9–CM codes.

Comment: One commenter, a national hospital association, opposed at this time the reassignment of a large number of diagnosis codes from the ''major problems'' list in DRGs 387 and 389 to DRG 391. The commenter agreed that refinements to MDC 15 would be beneficial to allow more accurate grouping of neonatal admissions but recommended that, prior to making extensive changes, CMS work with NACHRI, the commenter, and other interested parties to develop a separate DRG that would group neonates with minor problems that are not otherwise recognized currently or under the proposed changes.

Other commenters, representing hospitals, medical groups, and medical coders, offered a similar comment. One commenter stated that since NACHRI represents specialty hospitals, NACHRI's data may not fully represent the entire newborn population. Other commenters recommended that the proposed revisions to DRGs 387 through 391 not be implemented until input is obtained from representatives of general community hospitals that treat newborns. The commenters stated that newborn DRG data from general community hospitals may vary significantly from NACHRI's data and should be taken into consideration prior to implementing the proposed revisions to DRGs 387 through 391.

One commenter also stated that, while it supported the proposed removal of the listed codes for congenital anomalies, periventricular leukomalacia, and nonspecific abnormal findings on chromosomal analysis from MDC 15, the commenter was confused as to the rationale for the proposed DRG assignments for the codes for congenital anomalies. (We proposed that code 759.4, Conjoined twins, be classified to DRGs 188, 189, and 190.) In addition, several commenters stated that these DRGs are for digestive system diagnoses and conjoined twins may or may not have medical conditions involving the digestive system. The commenters stated that the rationale for the selection of these DRGs was not described in the proposed rule.

One commenter stated that additional study of newborn DRG classifications was needed. This commenter recommended that when cardiac surgery procedures are performed on neonates born in the hospital, the case be assigned to the applicable cardiac surgery DRG instead of one of the neonatal DRGs. The commenter pointed out that when a baby is born in a hospital and surgery is performed on a congenital heart condition during the same stay, the newborn is assigned to DRG 389 where the relative weight is approximately one-half the weight of the applicable cardiac surgery DRG. When the newborn is delivered at another facility and then transferred for surgery, the newborn is assigned to the appropriate cardiac surgery DRG. The commenter recommended that this issue be considered when MDC 15 is revised.

Response: The commenters raised a number of important issues. We solicited the assistance of NACHRI to develop refinements to MDC 15 because, while MDC 15 is part of the Medicare DRG system, the types of patients in classified to DRGs in MDC 15 are not a significant part of the Medicare program. It was our goal to develop refinements that could be useful for non-Medicare purposes. Given the extensive nature of the proposed revisions, we concur that additional study is necessary. Therefore, we are not implementing as final any of the proposed revisions to MDC 15. We are maintaining the existing structure of DRGs 385 through 390 within MDC 15 (Version 19.0) for FY 2003. Nonetheless we believe that changes in this area may be worthwhile, and we would be interested in considering a set of appropriate changes that might be broadly acceptable to the affected community. If we receive such suggested changes by December 1, 2002, we would consider it as part of our annual review and updates to the DRG system for FY 2004. Any proposals could be included in the notice of proposed rulemaking for FY 2004, which is scheduled to be published in early Spring 2003. In the meantime, as stated earlier, we are not making any of the proposed changes to MDC 15 for FY 2003.

Comment: One commenter supported the creation of the new ICD–9–CM codes that differentiate between extreme immaturity or gestational age, or both.

Response: As explained in the proposed rule, we are adding the new ICD–9–CM codes for newborns that were approved in 2002 for use by acute care hospitals in FY 2003. These codes are listed in Table 6A of this final rule. The codes are assigned to the existing DRGs as indicated in Table 6A under the column ''DRG'' (codes 747.83 through 779.89). Tables 6A through 6F in this final rule also reflect the assignment of these new codes.

Comment: One commenter pointed out several typographical errors and omissions in the proposed changes for MDC 15 in the proposed rule.

Response: The commenter is correct that there were typographical errors in the proposed rule. However, since we are not finalizing the proposed changes, we are not addressing the errors specifically in this final rule. We will provide clarifications of these errors to those interested parties who participating in future efforts to refine MDC 15.

7. MDC 23 (Factors Influencing Health Status and Other Contacts With Health Services)

In the August 1, 2001 final rule, we included in Table 6A-New Diagnosis Codes (66 FR 40064) code V10.53 (History of malignancy, renal pelvis), which was approved by the ICD–9–CM Coordination and Maintenance Committee as a new code effective October 1, 2001. We assigned the code to DRG 411 (History of Malignancy without Endoscopy) and DRG 412 (History of Malignancy with Endoscopy).

We received correspondence that suggested that we should have also

assigned code V10.53 to DRG 465 (Aftercare with History of Malignancy as Secondary Diagnosis). The correspondent pointed out that all other codes for a history of malignancy are included in DRG 465.

We agree that code V10.53 should be included in the list of the history of malignancy codes within DRG 465.

We received several comments in support of this change. Accordingly, in this final rule we are adding code V10.53 to the list of secondary diagnosis in DRG 465, effective for discharges occurring on or after October 1, 2002.

8. Pre-MDC: Tracheostomy

DRG 483 (Tracheostomy Except for Face, Mouth and Neck Diagnoses) is used to classify patients who require long-term mechanical ventilation. Mechanical ventilation can be administered through an endotracheal tube for a limited period of time. When an endotracheal tube is used for an extended period of time (beyond 7 to 10 days), the patient runs a high risk of permanent damage to the trachea. In order to maintain a patient on mechanical ventilation for a longer period of time, the endotracheal tube is removed and a tracheostomy is performed. The mechanical ventilation is then administered through the tracheostomy.

A tracheostomy also may be performed on patients for therapeutic purposes unrelated to the administration of mechanical ventilation. Patients with certain face, mouth, and neck disease may have a tracheostomy performed as part of the treatment for the face, mouth, or neck disease. These patients are assigned to DRG 482 (Tracheostomy for Face, Mouth and Neck Diagnoses).

Therefore, patients assigned to DRGs 482 and 483 are differentiated based on the principal diagnosis of the patient. At certain times, selecting the appropriate principal diagnosis for the patients receiving tracheostomies for assignment to a DRG can be difficult. The overall number of tracheostomy patients increased by 13 percent between 1994 and 1999. During the same period, the percent of tracheostomy patients in DRG 483 (patients without certain face, mouth, or neck diseases) versus DRG 482 increased from 83.6 percent to 87.6 percent.

The payment weight for DRG 483 is more than four times greater than the DRG 482 payment weight, and this has led to concerns about coding compliance. Specifically, the fact that cases are assigned to DRG 483 based on the absence of a code indicating face, mouth, or neck diagnosis creates an incentive to omit codes indicating these diagnoses.

To address issues of possible coding noncompliance, we proposed to modify DRGs 482 and 483 to differentiate the assignment to either DRG based on the presence or absence of continuous mechanical ventilation that lasts more than 96 hours (code 96.72). This modification would ensure that the patients assigned to DRG 483 are patients who had the tracheostomy for long-term mechanical ventilation. Based on an examination of claims data from the FY 2001 MedPAR file, we found that many patients assigned to DRG 483 do not have the code 96.72 for continuous mechanical ventilation for 96 consecutive hours or more recorded. In part, this is the result of the limited number of procedure codes (six) that can be submitted on the current uniform hospital claim form, and the fact that code 96.72 does not currently affect the DRG assignment.

We proposed to change the definition of DRG 483 so that patients who have a tracheostomy and continuous mechanical ventilation greater than 96 hours (code 96.72) would be assigned to DRG 483. We would continue to assign to DRG 483 those patients who have a principal diagnosis unrelated to disease of the face, mouth, or neck and a tracheostomy. We proposed to retitle DRG 483 ''Tracheostomy/Mechanical Ventilation 96+ Hours Except Face, Mouth, and Neck Diagnosis.''

In the proposed rule, we indicated that we would give future consideration to modifying DRGs 482 and DRG 483 based on the presence of code 96.72, and specifically invited comments on this area.

Comment: Several commenters representing hospital associations and medical groups supported the proposed modification to DRG 483. Some commenters strongly supported using code 96.72 as a determining factor for assigning ventilator patients to DRG 483. Another commenter indicated that the proposal was a more accurate means of identifying high-cost ventilator patients.

One commenter representing medical coders opposed the proposed modification. The commenter expressed concern that there were no supporting data to justify the revision. The commenter pointed out that it was not clear to which DRG tracheostomy patients with mechanical ventilation of less than 96 hours and with out a face, neck, or mouth diagnosis would be classified, since no modification to DRG 482 was proposed. The commenter did note that CMS was encouraging the reporting of code 96.72, but believed that this might be a problem when a number of other significant operative procedures are performed, given the limited spaces available on the claim form to report ICD–9–CM procedure codes.

Response: The proposed change was a first attempt to refine DRGs 482 and 483 so that those patients who receive long-term (> 96 hours) mechanical ventilation are separated from those patients who receive mechanical ventilation of less than 96 hours. The proposed change to DRG 483 was partially in response to concern that hospitals could omit diagnosis codes indicating face, mouth, or neck diagnosis in order to have cases assigned to DRG 483 rather than the much lower paying DRG 482. It also was an attempt to improve the classification of patients on mechanical ventilation by identifying those who receive long-term use of a ventilator. By making the GROUPER recognize long-term mechanical ventilation and assigning those patients to the higher weighted DRG 483, we hoped that hospitals would be more aware of the importance of reporting code 96.72 when, in fact, patients had been on the ventilator for greater than 96 hours. Therefore, hospitals would appropriately increase the reporting of this code. This reporting would allow us to continue to refine DRGs 482 and 483 to better reflect the resource utilization of these cases.

We agree with the commenter that hospitals frequently are faced with cases where more than six procedures are performed during the inpatient stay and that there are limited spaces available on the claims form for reporting procedure codes. The proposed change encourages hospitals to begin to report code 96.72, since it will effect DRG assignment.

The commenter was correct; we were not completely clear in the proposed rule about the effect that the addition of code 96.72 would have on DRG 482. The change will have an impact on DRG 482. All cases involving a tracheostomy and a diagnosis of face, mouth, and neck diagnosis that also have been on continuous mechanical ventilation for greater than 96 hours (code 96.72) will be moved out of DRG 482 and into DRG 483. The effect is that the expensive, long-term mechanical ventilation cases will be moved out of DRG 482 and into the higher-weighted DRG 483. As mentioned earlier, we did not propose any DRG modification involving patients who receive a tracheostomy, have mechanical ventilation of less than 96 hours, and do not have a face, neck, or mouth diagnosis. These cases will continue to be assigned to DRG 483.

Should future data indicate a need for further refinement of DRGs 482 and 483, we would propose these changes at that time. The public would be given an opportunity to comment on these proposals through the normal notice-and-comment rulemaking process.

In this final rule, we are adopting as final the proposed change in the definition of DRG 483 and the proposed change to add code 96.72 to DRG 483. To further clarify this change, we are changing the title of DRG 483 to ''Tracheostomy with Mechanical Ventilation 96 + Hours or Principal Diagnosis Except Face, Mouth, and Neck.''

9. Medicare Code Editor (MCE) Change

As explained under section II.B.1. of this preamble, the MCE is a software program that detects and reports errors in the coding of Medicare claims data.

The MCE includes an edit for ''nonspecific principal diagnosis'' that identifies a group of codes that are valid according to the ICD–9–CM coding scheme, but are not as specific as the coding scheme permits. The fiscal intermediaries use cases identified in this edit for educational purposes for hospitals only. That is, when a hospital reaches a specific threshold of cases (usually 25) in this edit, the fiscal intermediary will contact the hospital and educate it on how to code diagnoses using more specific codes in the ICD–9–CM coding scheme.

Code 436 (Acute, but ill-defined, cerebrovascular disease) is one of the codes included in the groups of codes identified in the nonspecific principal diagnosis edit, and is widely used in smaller hospitals where testing mechanisms are not available or have not been utilized to more specifically identify the location and condition of cerebral and precerebral vessels. Because of the frequent use of code 436 among smaller hospitals, we proposed to remove the code from the nonspecific principal diagnosis edit in the MCE. We address the use of code 436 in section II.B.3. of this final rule under the discussion of MDC 5 changes with regard to the remodeling of DRGs 14 and 15.

We received two comments in support of this proposal. However, one of the commenters noted that code 436 is not just limited to use in smaller hospitals, as we stated in the proposed rule. We acknowledge the commenters remarks that code 436 is widely used in hospitals of all sizes and is not exclusively used in smaller hospitals. However, our rationale for removing code 436 from the MCE because it is frequently used, still holds. Accordingly, we are adopting as final the proposed removal of code 436 from the MCE ''nonspecific principal diagnisis'' edit, effective with discharges occurring on or after October 1, 2002.

10. Surgical Hierarchies

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. Therefore, it is necessary to have a decision rule within the GROUPER by which these cases are assigned to a single DRG. The surgical hierarchy, an ordering of surgical classes from most resource-intensive to least resource-intensive, performs that function. Its application ensures that cases involving multiple surgical procedures are assigned to the DRG associated with the most resource-intensive surgical class.

Because the relative resource intensity of surgical classes can shift as a function of DRG reclassification and recalibrations, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications and recalibrations, to determine if the ordering of classes coincides with the intensity of resource utilization.

A surgical class can be composed of one or more DRGs. For example, in MDC 11, the surgical class ''kidney transplant'' consists of a single DRG (DRG 302) and the class ''kidney, ureter and major bladder procedures'' consists of three DRGs (DRGs 303, 304, and 305). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class involves weighting the average resources for each DRG by frequency to determine the weighted average resources for each surgical class. For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5. Assume also that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average charge of each DRG in the class by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of ''other O.R. procedures'' as discussed below.

This methodology may occasionally result in assignment of a case involving multiple procedures to the lower-weighted DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPER searches for the procedure in the most resource-intensive surgical class, this result is unavoidable.

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average charge is ordered above a surgical class with a higher average charge. For example, the ''other O.R. procedures'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the average charge for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The ''other O.R. procedures'' class is a group of procedures that are only infrequently related to the diagnoses in the MDC but are still occasionally performed on patients in the MDC with these diagnoses. Therefore, these procedures should only be considered if no other procedure more closely related to the diagnoses in the MDC has been performed.

A second example occurs when the difference between the average charges for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy since, as a result of the hierarchy change, the average charges are likely to shift such that the higher-ordered surgical class has a lower average charge than the class ordered below it.

In the May 9, 2002, we proposed to revise the surgical hierarchy for the pre-MDC DRGs and for MDC 5 (Diseases and Disorders of the Circulatory System) as follows:

- In the pre-MDC DRGs, we proposed to reorder DRG 495 (Lung Transplant) above DRG 512 (Simultaneous Pancreas/Kidney Transplant).
- In MDC 5, we proposed to reorder DRG 525 (Heart Assist System Implant) above DRGs 104 and 105 (Cardiac Valve and Other Major Cardiothoracic Procedures with and without Cardiac Catheterization, respectively).

In the proposed rule, we were unable to test the effects of the proposed revisions to the surgical hierarchy and to reflect these changes in the proposed relative weights because the revised GROUPER software was unavailable at the time the proposed rule was completed. Rather, we simulated most major classification changes to

approximate the placement of cases under the proposed reclassification, and then determined the average charge for each DRG. These average charges served as our best estimate of relative resources used for each surgical class. We have now tested the proposed surgical hierarchy changes after the revised GROUPER was received and are reflecting the final changes in the DRG relative weights in this final rule. Further, as discussed in section II.C. of this preamble, the final recalibrated weights are somewhat different from the proposed weights because they were based on more complete data.

Based on a test of the proposed revisions using the April 2002 update of the FY 2001 MedPAR file and the revised GROUPER software, we have found that the revisions are still supported by the data, and no additional changes are indicated except those discussed below pertaining to the implementation of two new cardiac drug-eluting stent DRGs. (For a complete description of this change, see the discussion under ''Other Issues'' in section II.B.14. of this preamble.) Due to the implementation of two new DRGs pertaining to cardiac drug-eluting stents, DRGs 526 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with AMI) and 527 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent without AMI), we also are reordering the following DRGs in MDC 5: DRGs 115 (Permanent Cardiac Pacemaker Implant with AMI, Heart Failure or Stroke, or AICD Lead or and Generator Procedure) and 116 (Other Permanent Cardiac Pacemaker Implant) above DRG 526; DRG 526 above DRG 516 (Percutaneous Cardiovascular Procedures with Acute Myocardial Infarction (AMI)); DRG 516 above DRG 527; DRG 527 above DRG 517 (Percutaneous Cardiovascular Procedure without AMI, with Coronary Artery Stent Implant); DRG 517 above DRG 518 (Percutaneous Cardiovascular Procedures without AMI, without Coronary Artery Stent Implant); and DRG 518 above DRGs 478 (Other Vascular Procedures with CC) and 479 (Other Vascular Procedures without CC).

11. Refinement of Complications and Comorbidities (CC) List

In the September 1, 1987 final notice (52 FR 33143) concerning changes to the DRG classification system, we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered valid CCs in combination with a particular principal diagnosis. Thus, we created the CC Exclusions List. We made these changes for the following reasons: (1) To preclude coding of CCs for closely related conditions; (2) to preclude duplicative coding or inconsistent coding from being treated as CCs; and (3) to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. We developed this standard list of diagnoses using physician panels to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting CCs already on the list. In the May 9, 2002 proposed rule, we did not propose to delete any of the diagnosis codes on the CC list.

In the May 19, 1987 proposed notice (52 FR 18877) concerning changes to the DRG classification system, we explained that the excluded secondary diagnoses were established using the following five principles:

- Chronic and acute manifestations of the same condition should not be considered CCs for one another (as subsequently corrected in the September 1, 1987 final notice (52 FR 33154)).
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for the same condition should not be considered CCs for one another.
- Codes for the same condition that cannot coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.
- Codes for the same condition in anatomically proximal sites should not be considered CCs for one another.
- Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. The FY 1988 revisions were intended only as a first step toward refinement of the CC list in that the criteria used for eliminating certain diagnoses from consideration as CCs were intended to identify only the most obvious diagnoses that should not be considered CCs of another diagnosis. For that reason, and in light of comments and questions on the CC list, we have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC. (See the September 30, 1988 final rule (53 FR 38485) for the revision made for the discharges occurring in FY 1989; the September 1, 1989 final rule (54 FR 36552) for the FY 1990 revision; the September 4, 1990 final rule (55 FR 36126) for the FY 1991 revision; the August 30, 1991 final rule (56 FR 43209) for the FY 1992 revision; the September 1, 1992 final rule (57 FR 39753) for the FY 1993 revision; the September 1, 1993 final rule (58 FR 46278) for the FY 1994 revisions; the September 1, 1994 final rule (59 FR 45334) for the FY 1995 revisions; the September 1, 1995 final rule (60 FR 45782) for the FY 1996 revisions; the August 30, 1996 final rule (61 FR 46171) for the FY 1997 revisions; the August 29, 1997 final rule (62 FR 45966) for the FY 1998 revisions; the July 31, 1998 final rule (63 FR 40954) for the FY 1999 revisions, the August 1, 2000 final rule (65 FR 47064) for the FY 2001 revisions; and the August 1, 2001 final rule (66 FR 39851) for the FY 2002 revisions. In the July 30, 1999 final rule (64 FR 41490), we did not modify the CC Exclusions List for FY 2000 because we did not make any changes to the ICD–9–CM codes for FY 2000.

In this final rule, we are making limited revisions of the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2002. (See section II.B.13. of this preamble for a discussion of ICD–9–CM changes.) These changes are being made in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6G and 6H in the Addendum to this final rule contain the revisions to the CC Exclusions List that will be effective for discharges occurring on or after October 1, 2002. Each table shows the principal diagnoses with changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk, and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6G—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 2002, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6H—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 2002, the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical

Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $133.00 plus shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number (PB) 88–133970) should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161; or by calling (800) 553–6847.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, and 2002) and those in Tables 6F and 6G of this FY 2003 final rule must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 2002. (Note: There was no CC Exclusions List in FY 2001 because we did not make changes to the ICD–9–CM codes for FY 2001.)

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 19.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 20.0 of this manual, which includes the final FY 2002 DRG changes, is available for $225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

We received no comments on our proposed changes to the CC list, and we are adopting the changes as final.

12. Review of Procedure Codes in DRGs 468, 476, and 477

Each year, we review cases assigned to DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis), DRG 476 (Prostatic O.R. Procedure Unrelated to Principal Diagnosis), and DRG 477 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis) to determine whether it would be appropriate to change the procedures assigned among these DRGs.

DRGs 468, 476, and 477 are reserved for those cases in which none of the O.R. procedures performed are related to the principal diagnosis. These DRGs are intended to capture atypical cases, that is, those cases not occurring with sufficient frequency to represent a distinct, recognizable clinical group. DRG 476 is assigned to those discharges in which one or more of the following prostatic procedures are performed and are unrelated to the principal diagnosis:

60.0 Incision of prostate
60.12 Open biopsy of prostate
60.15 Biopsy of periprostatic tissue
60.18 Other diagnostic procedures on prostate and periprostatic tissue
60.21 Transurethral prostatectomy
60.29 Other transurethral prostatectomy
60.61 Local excision of lesion of prostate
60.69 Prostatectomy NEC
60.81 Incision of periprostatic tissue
60.82 Excision of periprostatic tissue
60.93 Repair of prostate
60.94 Control of (postoperative) hemorrhage of prostate
60.95 Transurethral balloon dilation of the prostatic urethra
60.99 Other operations on prostate

All remaining O.R. procedures are assigned to DRGs 468 and 477, with DRG 477 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis. The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV of the Addendum to the September 30, 1988 final rule (53 FR 38591). As part of the final rules published on September 4, 1990 (55 FR 36135), August 30, 1991 (56 FR 43212), September 1, 1992 (57 FR 23625), September 1, 1993 (58 FR 46279), September 1, 1994 (59 FR 45336), September 1, 1995 (60 FR 45783), August 30, 1996 (61 FR 46173), and August 29, 1997 (62 FR 45981), we moved several other procedures from DRG 468 to 477, and some procedures from DRG 477 to 468. No procedures were moved in FY 1999, as noted in the July 31, 1998 final rule (63 FR 40962); in FY 2000, as noted in the July 30, 1999 final rule (64 FR 41496); in FY 2001, as noted in the August 1, 2000 final rule (65 FR 47064); or in FY 2002, as noted in the August 1, 2001 final rule (66 FR 39852).

a. Moving Procedure Codes From DRGs 468 or 477 to MDCs

We annually conduct a review of procedures producing assignment to DRG 468 or DRG 477 on the basis of volume, by procedure, to see if it would be appropriate to move procedure codes out of these DRGs into one of the surgical DRGs for the MDC into which the principal diagnosis falls. The data are arrayed two ways for comparison purposes. We look at a frequency count of each major operative procedure code. We also compare procedures across MDCs by volume of procedure codes within each MDC.

We identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, we did not identify any necessary changes in procedures under DRG 477. Therefore, we did not propose to move any procedures from DRG 477 to one of the surgical DRGs. However, we have identified a number of procedure codes that should be removed from DRG 468 and put into more clinically coherent DRGs. The assignments of these codes are specified in the charts below.

MOVEMENT OF PROCEDURE CODES FROM DRG 468

Procedure code	Description	Included in DRG	Description
MDC 6.—Diseases and Disorders of the Digestive System			
387	Interruption vena cava	170	Other Digestive System O.R. Procedures with CC.
387	Interruption vena cava	171	Other Digestive System O.R. Procedures without CC.
3950	Angioplasty or atherectomy of noncoronary vessel	170	Other Digestive System O.R. Procedures with CC.
3950	Angioplasty or atherectomy of noncoronary vessel	171	Other Digestive System O.R. Procedures without CC.
MDC 7—Diseases and Disorders of the Hepatobiliary System and Pancreas			
387	Interruption vena cava	201	Other Hepatobiliary & Pancreas Procedures.

MOVEMENT OF PROCEDURE CODES FROM DRG 468—Continued

Procedure code	Description	Included in DRG	Description
3949	Other revision of vascular procedure	201	Other Hepatobiliary & Pancreas Procedures.
3950	Angioplasty or atherectomy of noncoronary vessel	201	Other Hepatobiliary & Pancreas Procedures.
MDC 8—Diseases and Disorders of the Musculoskeletal System and Connective Tissue			
387	Interruption vena cava	233	Other Musculoskeletal System & Connective Tissue O.R. Procedures with CC.
387	Interruption vena cava	234	Other Musculoskeletal System & Connective Tissue O.R. Procedures without CC.
3950	Angioplasty or atherectomy of noncoronary vessel	233	Other Musculoskeletal System & Connective Tissue O.R. Procedures with CC.
3950	Angioplasty or atherectomy of noncoronary vessel	234	Other Musculoskeletal System & Connective Tissue O.R. Procedures without CC.
MDC 9—Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast			
8344	Other fasciectomy	269	Other Skin, Subcutaneous Tissue & Breast Procedures with CC.
8344	Other fasciectomy	270	Other Skin, Subcutaneous Tissue & Breast Procedures without CC.
8345	Other myectomy	269	Other Skin, Subcutaneous Tissue & Breast Procedures with CC.
8345	Other myectomy	270	Other Skin, Subcutaneous Tissue & Breast Procedures without CC.
8382	Muscle or fascia graft	269	Other Skin, Subcutaneous Tissue & Breast Procedures with CC.
8382	Muscle or fascia graft	270	Other Skin, Subcutaneous Tissue & Breast Procedures without CC.
MDC 10—Endocrine, Nutritional and Metabolic Diseases and Disorders			
387	Interruption vena cava	292	Other Endocrine, Nutritional, & Metabolic O.R. Procedures with CC.
387	Interruption vena cava	293	Other Endocrine, Nutritional, & Metabolic O.R. Procedures without CC.
5459	Other Lysis of Peritoneal adhesions	292	Other Endocrine, Nutritional, & Metabolic O.R. Procedures with CC.
5459	Other Lysis of Peritoneal adhesions	293	Other Endocrine, Nutritional, & Metabolic O.R. Procedures without CC.
MDC 11—Diseases and Disorders of the Kidney and Urinary Tract			
0492	Implantation or replacement of peripheral neuro-stimulator.	315	Other Kidney & Urinary Tract O.R. Procedures.
3821	Blood vessel biopsy	315	Other Kidney & Urinary Tract O.R. Procedures.
387	Interruption vena cava	315	Other Kidney & Urinary Tract O.R. Procedures.
3949	Other revision of vascular procedure	315	Other Kidney & Urinary Tract O.R. Procedures.
MDC 12—Diseases and Disorders Male Reproductive System			
387	Interruption vena cava	344	Other Male Reproductive System O.R. Procedures for Malignancy.
387	Interruption vena cava	345	Other Male Reproductive System O.R. Procedures Except for Malignancy.
8622	Excisional debridement of wound, infection, or burn	344	Other Male Reproductive System O.R. Procedures for Malignancy.
8622	Excisional debridement of wound, infection, or burn	345	Other Male Reproductive System O.R. Procedures Except for Malignancy.
MDC 13—Diseases and Disorders of the Female Reproductive System			
387	Interruption vena cava	365	Other Female Reproductive System O.R. Procedures.
MDC 16—Diseases and Disorders of the Blood, Blood Forming Organs, Immunological Disorders			
387	Interruption vena cava	394	Other O.R. Procedures of the Blood & Blood Forming Organs.

We did not receive any comments on the proposed movement of procedures codes from DRG 468. Accordingly, we are adopting, as final, the movement of the codes as outlined above.

b. Reassignment of Procedures Among DRGs 468, 476, and 477

We also annually review the list of ICD–9–CM procedures that, when in combination with their principal diagnosis code, result in assignment to DRGs 468, 476, and 477, to ascertain if any of those procedures should be reassigned from one of these DRGs to another of these DRGs based on average charges and length of stay. We look at the data for trends such as shifts in treatment practice or reporting practice that would make the resulting DRG assignment illogical. If we find these shifts, we would move cases to keep the DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on our review this year, we are not moving any procedures from DRG 468 to DRGs 476 or 477, from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGs 468 or 476.

c. Adding Diagnosis Codes to MDCs

Based on our review this year, we are not adding any diagnosis codes to MDCs.

13. Changes to the ICD–9–CM Coding System

As described in section II.B.1. of this preamble, the ICD–9–CM is a coding system that is used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD–9–CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS) and CMS, charged with maintaining and updating the ICD–9–CM system. The Committee is jointly responsible for approving coding changes, and developing errata, addenda, and other modifications to the ICD–9–CM to reflect newly developed procedures and technologies and newly identified diseases. The Committee is also responsible for promoting the use of Federal and non-Federal educational programs and other communication techniques with a view toward standardizing coding applications and upgrading the quality of the classification system.

The ICD–9–CM Manual contains the list of valid diagnosis and procedure codes. (The ICD–9–CM Manual is available from the Government Printing Office on CD–ROM for $22.00 by calling (202) 512–1800.) The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases,* while CMS has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures of the Manual.*

The Committee encourages participation in the above process by health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding field, such as the American Health Information Management Association (AHIMA) (formerly American Medical Record Association (AMRA)), the American Hospital Association (AHA), and various physician specialty groups as well as physicians, medical record administrators, health information management professionals, and other members of the public, to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes for implementation in FY 2003 at public meetings held on May 17 and 18, 2001, and November 1 and 2, 2001, and finalized the coding changes after consideration of comments received at the meetings and in writing by January 8, 2002.

We described our plans to expedite the implementation of coding changes in the September 7, 2001 **Federal Register**, including moving the dates of the ICD–9–CM Coordination and Maintenance Committee to December and April of each year. We also established the possibility of implementing procedure codes discussed in the April meeting as part of the October update in the same year. This reduces the time for activating a new code from a minimum of 11 months to a minimum of 6 months.

Because the changes would not be included in the proposed rule published in the spring, the public would be given less opportunity to consider the merits of the proposals. Decisions from the spring meeting must be finalized by early June in order to be included in changes in the GROUPER software and be effective October 1. The addenda must also be published on the homepage and distributed to publishers so that both paper versions of the ICD–9–CM code book and software applications can be ready in time for use by health care providers. Only those issues from the April meeting that could be quickly resolved and that received support from the public would be able to be included in the October addendum. Those that could not be quickly resolved would continue to be addressed as part of the addendum for October 1 of the next year.

The ICD–9–CM Coordination and Maintenance Committee met on April 18 and 19, 2002. Two code title issues discussed during that meeting were approved in time to be included in the Addendum of this final rule, to be effective October 1, 2002. These codes are new code 89.60 (Continuous intra-arterial blood gas monitoring) which is shown in Table 6B in the Addendum of this final rule, and revised code title 02.41 (Irrigation and exploration of ventricular shunt) which is shown in Table 6F in the Addendum of this final rule.

For a report of procedure topics discussed at the April 2002 meeting, see the Summary Report at: *http://www.cms.hhs.gov/medicare/icd9cm.asp.* This site also includes the Final Addendum for ICD–9–CM Procedures, which will be effective October 1, 2002.

Copies of the Coordination and Maintenance Committee minutes of the 2001 meetings can be obtained from the CMS home page at: *http://www.cms.gov/medicare/icd9cm.asp.* Paper copies of these minutes are no longer available and the mailing list has been discontinued. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; NCHS; Room 1100; 6525 Belcrest Road; Hyattsville, MD 20782. Comments may be sent by E-mail to: *dfp4@cdc.gov.*

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; CMS, Center for Medicare Management, Purchasing Policy Group, Division of Acute Care; C4–08–06; 7500 Security Boulevard; Baltimore, MD 21244–1850. Comments may be sent by E-mail to: *pbrooks@cms.hhs.gov.*

The ICD–9–CM code changes that have been approved will become effective October 1, 2002. The new ICD–9–CM codes are listed, along with their DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the

Addendum to this final rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In the proposed rule, we only solicited comments on the proposed DRG classification of these new codes.

For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A (New Diagnosis Codes) in the Addendum of this final rule. New procedure codes are shown in Table 6B. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2002. Table 6C contains invalid diagnosis codes. There are no invalid procedure codes for FY 2002 (Table 6D). Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also includes the DRG assignments for these revised codes. Revisions to procedure code titles are in Table 6F (Revised Procedure Codes Titles).

Comment: One commenter expressed concern about making procedure code changes discussed at the April ICD–9–CM Coordination and Maintenance Committee effective the following October. The commenter had concerns with the fact that these coding changes would not be discussed in the proposed rule, but would appear in the final rule. The commenter indicated that hospitals need time to comment on all proposed changes to the DRGS and to analyze changes for budgeting, train staff on coding changes, and implement software changes. The commenter also endorsed movements toward replacing ICD–9–CM with ICD–10–PCS and believed this would improve coded data. In addition, the commenter suggested that consideration be given to using Alpha-numeric HCPCS codes to report the use of drugs, supplies, and devices used for inpatients, instead of trying to make ICD–9–CM serve this purpose.

Response: We discussed the issue of consideration of coding changes at the April meeting of the Committee in the final rule on Payment for New Medical Services and New Technologies Under the Acute Care Hospital Inpatient Prospective Payment System published in the **Federal Register** on September 7, 2001 (66 FR 46902). We were responding to section 533 of Public Law 106–554, which provided for expediting the incorporation of new services into the coding system. While we recognize the commenter's concern, we also are responding to repeated requests to expedite our process of updating codes. We will carefully evaluate requests for new codes that are discussed at the April ICD–9–CM Coordination and Maintenance Committee to determine which codes can and should be included in the addendum on ICD–9–CM effective October of each year. We encourage the commenter to continue to participate in the process by attending these public meetings and offering its opinions.

On the issue of the movement to ICD–10–PCS and the possibility of using HCPCS codes for inpatient reporting, we note this issue is currently under review by the National Committee on Vital and Health Statistics (NCVHS). This committee advises the Secretary on coding standards issues under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The committee is currently conducting public meetings on the issues raised by this commenter. We will defer issues involving changes to the HIPAA standards to the NCVHS. For more information on this committee, please see its web site at: *http://www.ncvhs.hhs.gov/.*

14. Other Issues

In addition to the specific topics discussed in section II.B.1. through 13. of this final rule, we addressed a number of other DRG-related issues in the May 9, 2002 proposed rule. In the proposed rule, we did not propose any changes to the DRGs relating to the issues. Below is a summary of the issues that were addressed, any public comments we received, and our responses to those comments.

a. Intestinal Transplantation

We examined our data to determine whether it is appropriate to add a new intestinal transplant DRG. Our data revealed that nine intestinal transplantation cases were reported by two facilities. Of the nine cases, two cases involved a liver transplant during the same admission and, therefore, would be assigned to DRG 480 (Liver Transplant). As we stated in the proposed rule, we do not believe that the remaining seven cases provide a sufficient number to warrant the creation of a new intestinal transplant DRG.

Comment: Commenters supported the proposal not to create a separate new DRG for intestinal transplants and pointed out that this procedure is not being widely performed.

Response: We will continue to monitor intestinal transplantation cases to determine whether it may be appropriate in the future to establish a new DRG for the intestinal transplant procedure.

b. Myasthenia Gravis

Myasthenia Gravis is an autoimmune disease manifested by a syndrome of fatigue and exhaustion of the muscles that is aggravated by activity and relieved by rest. The weakness of the muscles can range from very mild to life-threatening.

This disease is classified to ICD–9–CM diagnosis code 358.0 and is assigned to DRG 12 (Degenerative Nervous System Disorders). Myasthenia Gravis in crisis patients is being treated with extensive plasmapheresis. We received a request to analyze the charges associated with Myasthenia Gravis in crisis patients receiving plasmapheresis to determine whether DRG 12 is an equitable DRG assignment for these cases. We are currently unable to differentiate between the mild and severe forms of this disease because all types are classified to code 358.0. Therefore, we requested the NCHS to create a new diagnosis code for Myasthenia Gravis in crisis so that we can uniquely identify these cases to ensure the DRG assignment is appropriate.

Comment: Commenters supported the creation of a new diagnosis code so that Myasthenia Gravis in crisis patients can be uniquely identified and the mild and severe forms of the disease is distinguished.

Response: This topic was addressed at the April 18, 2002 ICM–9–CM Coordination and Maintenance Committee meeting. NCHS proposed two new codes to capture Myasthenia Gravis not in crisis and Myasthenia Gravis in crisis. If the Committee approves these two codes, they would not become effective until October 1, 2003. At that point, we would be able to assess the charges associated with Myasthenia Gravis in crisis patients receiving plasmapheresis.

c. Cardiac Mapping and Ablation

In the August 1, 2001 final rule (66 FR 39840), in response to a comment received, we agreed to continue to evaluate DRGs 516 (Percutaneous Cardiovascular Procedure with Acute Myocardial Infarction (AMI)), 517 (Percutaneous Cardiovascular Procedure with Coronary Artery Stent without AMI), and 518 (Percutaneous Cardiovascular Procedure without

Coronary Artery Stent or AMI) in MDC 5. For the proposed rule, we reviewed code 37.26 (Cardiac electrophysiologic stimulation and recording studies), code 37.27 (Cardiac mapping), and code 37.34 (Catheter ablation of lesion or tissues of heart). The commenter had recommended that CMS either create a separate DRG for cardiac mapping and ablation procedures, or assign codes 37.27 and 37.34 to DRG 516 after retitling the DRG. We have reviewed FY 2001 MedPAR data on these specific codes. Over 97 percent of cases with these codes were assigned to DRG 518 and had average charges of $1,741 below the average for all cases in the DRG. Therefore, the data do not support making any DRG changes for these procedure codes.

We received one comment in support of our proposal not to make DRG changes to the cardiac mapping and ablation codes. Accordingly, in this final rule, we will not make any changes relating to the DRG assignment of codes 37.20, 37.26, and 37.34

d. Aortic Endograft

In the August 1, 2001 final rule (66 FR 39841), we responded to a comment concerning the placement of aortic endografts in DRG 110 (Major Cardiovascular Procedures with CC) and DRG 111 (Major Cardiovascular Procedures without CC). The commenter noted that the cost of the device alone is greater than the entire payment for DRG 111 and recommended that these cases be assigned specifically to DRG 110. Our response at that time was that DRGs 110 and 111 are paired DRGs, differing only in the presence or absence of a CC.

We reviewed the MedPAR data again for FY 2001 using the following criteria: All cases were either in DRG 110 or 111, had a principal diagnosis of 441.4 (Abdominal aneurysm without mention of rupture), and included procedure code 39.71 (Endovascular implantation of graft in abdominal aorta). Our conclusion is that the majority of aneurysm cases are already grouped to DRG 110, where they are appropriately compensated. Therefore, we did not propose to assign cases without CCs from DRG 111 to DRG 110. We reiterate that hospitals are responsible for coding their records completely and for recording and submitting all relevant diagnosis and procedure codes that have a bearing on the current admission (in particular, any secondary or additional diagnosis codes that may be recognized by the GROUPER software as codes describing complications or comorbidities associated with a case).

Comment: One commenter recommended a new DRG due to the significant costs associated with the device.

Response: The commenter submitted no data that would cause us to question our findings described above. Therefore, in this final rule, we are not changing the current DRG assignment of procedure code 39.71. e. Platelet Inhibitors.

In the August 1, 2001 final rule (66 FR 39840), we addressed a commenter's concern that modifications to MDC 5 involving percutaneous cardiovascular procedures would fail to account for the use of GP IIB–IIIA platelet inhibiting drugs for cases with acute coronary syndromes. GROUPER does not recognize procedure code 99.20 (Injection or infusion of platelet inhibitor) as a procedure. Therefore, its presence on a claim does not affect DRG assignment. We agreed to continue to evaluate this issue.

For the May 9, 2002 proposed rule, we reviewed cases in the FY 2001 MedPAR file for DRG 121 (Circulatory Disorders with AMI and Major Complication, Discharged Alive), DRG 122 (Circulatory Disorders with AMI without Major Complication, Discharged Alive) and DRGs 516, 517, and 518. We looked at all cases in these DRGs containing procedure code 99.20 by total number of procedures and by average charges. There were a total of 73,480 cases where platelet inhibitors were administered, with 70,216 of these cases in DRGs 516, 517, and 518. The average charges for platelet inhibitor cases in these three DRGs are actually slightly below the average for all cases in the respective DRGs. Therefore, we believe these cases are appropriately placed in the current DRGs, and we did not propose any changes to the assignment of the procedure code 99.20.

We received one comment in support of maintaining the current DRG assignments of code 99.20. Therefore, in this final rule, we are not making any changes to the DRG assignments of code 99.20.

f. Drug-Eluting Stents

The drug-eluting stent technology has been developed to combat the problem of restenosis of blood vessels previously treated for stenosis. The drug is coated on a stent with a special polymer, and after the stent is placed in the vessel, the drug is slowly released into the vessel wall tissue over a period of 30 to 45 days. The drug coating on the stent is intended to prevent the build-up of scar tissue that can narrow the reopened artery.

In Table 6B of the Addendum to this final rule, we list a new procedure code 36.07 (Insertion of drug-eluting coronary artery stents(s)) that will be effective for use October 1, 2002. We also are adding code 00.55 (Insertion of drug-eluting noncoronary artery stent).

A manufacturer of this technology asserted that this technology is significantly more costly than other technologies currently assigned to DRG 517 (Percutaneous Cardiovascular Procedure with Coronary Artery Stent without AMI) (average charges of $29,189 compared to average charges of $22,998). The manufacturer requested that code 36.07 be assigned to DRG 516 (Percutaneous Cardiovascular Procedure with Acute Myocardial Infarction (AMI)) even without the presence of AMI.

In addition, the manufacturer argued that this technology should be given preferential treatment because it will fundamentally change the treatment of multivessel disease. Specifically, the manufacturer stated that due to the absence of restenosis in patients treated with the drug-eluting stents based on the preliminary trial results, bypass surgery may no longer be the preferred treatment for many patients.[1] The manufacturer believes lower payments due to the decline in Medicare bypass surgeries will offset the higher payments associated with assigning all cases receiving the drug-eluting stent to DRG 516.

The FDA has not yet approved this technology for use. In the May 9, 2002 proposed rule, we specifically solicited comments on our proposal to treat the new codes cited above consistent with the current DRG assignment for coronary artery stents. We also stated that if the technology is approved by the FDA and further evidence is presented to us regarding the clinical efficacy and the impact that this technology has on the treatment of multivessel disease, we may reassign this code to another DRG or reassess the construct of all affected DRGs.

Comment: Several commenters supported the development of new ICD–9–CM codes 36.07 and 00.55 for drug-eluting stents, citing the need for identification of this new technology. Several commenters supported the creation of new ICD–9–CM codes in order to ensure this technology would receive payment under Medicare.

Response: We created two new ICD–9–CM codes for use with cases

[1] "Comparison of Coronary-Artery Bypass Surgery and Stenting for the Treatment of Multivessel Disease," Serruys, P.W., Unger, F., et al., *The New England Journal of Medicine,* April 12, 2001, Vol. 344, No. 15, p. 1117.

involving discharges occurring on or after October 1, 2002. These codes can be found in Table 6B. ''New Procedure Codes'' in the Addendum of this final rule. However, we emphasize that it is not necessary to assign new technologies a new ICD–9–CM code in order for Medicare payment to commence. In the absence of a new code, technologies are assigned to the nearest similar existing code and, consequently, to the relevant DRG for payment.

Comment: Numerous comments opposed our proposed DRG assignment of code 36.07 to DRG 517. One commenter noted that, while this technology is not yet approved, it has shown promise to significantly advance the treatment of coronary artery disease, and encouraged CMS to consider the available data to determine the most appropriate paying DRG. This commenter supported the reassignment of code 36.07 to another DRG or, if necessary, the modification of all affected DRGs, once verifiable data on the costs associated with drug-eluting stents become available.

Many of the commenters who supported higher payment for this technology were clinical practitioners and hospitals who expressed great anticipation for the potential benefits of this technology. In addition, commenters referred to the likelihood that, once these new drug-eluting stents are approved, patients would demand to have them inserted. This demand would put tremendous financial strain on hospitals.

Commenters also argued there should be long-term cost savings to the Medicare program and the health system generally from this technology after approval by the FDA. Specifically, if dramatically fewer patients require restenting, savings will result from fewer repeat angioplasty procedures. Also, to the extent bypass surgeries are also reduced (as suggested by the article footnoted above), savings will result from that outcome as well.

Response: We note that, at this point, the FDA has not approved this technology for general use. However, we also note that public presentation of the results from recent clinical trials have found virtually no in-stent restenosis in patients treated with the drug-eluting stent. Therefore, we recognize the potentially significant impact this technology may conceivably have on the treatment of coronary artery blockages.

As we have previously stated, new technology is generally assigned to the same DRG as the predecessor technologies. In this way, hospitals can receive payment immediately for the new technology. As use of the new technology diffuses among hospitals, we have gradually and largely automatically recalibrated DRG payment rates based on hospital claims data to reflect increasing or decreasing costs of cases assigned to the DRG. Generally, it takes 2 years for claims data to be reflected in the DRG weights.

Section 533 of Public Law 106–554 added sections 1886(d)(5)(K) and (d)(5)(L) to the Act (as implemented by §§ 412.87 and 412.88) to reduce the time needed for the DRG system to recognize the higher costs of new technologies that meet certain criteria (see section II.D. of this final rule). However, drug-eluting stents did not meet the cost threshold criterion. Therefore, we proposed to assign cases involving code 36.07 to DRG 517. Although this DRG assignment would be consistent with our prior practice of assigning new technology to the same DRGs to which its predecessor technologies were assigned, further consideration of this issue persuades us that a different approach is needed, given the extraordinary circumstances in this particular instance.

We are concerned that, if the FDA does approve this technology and the predictions of its rapid, widespread use are accurate, this action will result in a significant strain on hospital financial resources. In particular, we are concerned that the higher costs of this technology would create undue financial hardships for hospitals due to the high volume of stent cases and the fact that a large proportion of these cases could involve the new technology soon after FDA approval. Therefore, in this final rule we are creating two new DRGs that parallel existing DRGs 516 and 517, to reflect cases involving the insertion of a drug-eluting coronary artery stent as signified by the presence of code 36.07: DRG 526 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with AMI); and DRG 527 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent without AMI). We understand the earliest date that a decision from the FDA is anticipated is late 2002. To further ensure that payments for the new DRGs 526 and 527 will not be made prior to FDA approval, we will activate these DRGs effective for discharges occurring on or after April 1, 2003. If the FDA approves the use of drug-eluting stents prior to April 1, 2003, cases coded with procedure code 36.07 will be paid using the DRG relative weights for DRG 517. New DRGs 526 and 527 will be temporary DRGs. By creating separate new DRGs, we are able to ensure that higher payments will only be made after a positive decision by the FDA. We expect that when claims data are available that reflect the use of these stents, we will combine drug-eluting stent cases with other cases in DRGs 516 and 517.

Although one manufacturer of this technology submitted data to us that included charges, hospital provider numbers, and admission and discharge dates on the Medicare patients for whom hospital bills were collected under the trial in order to demonstrate the higher average charges of cases included in the trial, much of the data submitted to us included only estimated charges for the new technology. Therefore, it was necessary to undertake several calculations to establish the DRG relative weights for these two new DRGs. First, based on prices in countries where drug-eluting stents are currently being used, and the average price of currently available stents, we calculated a price differential of approximately $1,200. Assuming average hospital charge markups for this technology (based on weighted average cost-to-charge ratios), the anticipated charge differential between old and new stents would be approximately $2,664 per stent. However, we recognize that some cases involve more than one stent. Using an average of 1.5 stents per procedure, the net estimated incremental charge for cases that would receive a drug-eluting stents is $3,996.

In order to accurately determine the DRG relative weights for these two new DRGs relative to all other DRGs, we must also estimate the volume of cases likely to occur in them among discharges occurring on or after April 1, 2003 and by September 30, 2003. To approximate the number of cases that would likely receive the drug-eluting stent between April 1, 2003 and September 30, 2003 (and thus would be assigned to new DRGs 526 and 527), we first identified cases in DRGs 516 and 517 with procedure code 36.06 (Insertion of non-drug-eluting coronary artery stent). Of these cases, we estimated what percentage would be likely to receive the drug-eluting stent after April 1, 2003. The manufacturer estimated that as many as 43 percent of current stent patients will receive drug-eluting stents during FY 2003. However, this estimate assumes 9 months of sales of the new stents during FY 2003, from January to September. Because these two new DRGs will only be valid for 6 months during FY 2003, from April through September, we estimated that 21.5 percent of all stent cases will be assigned to new DRGs 526 and 527 (43 percent of stent cases for 6 months instead of 9 months).

In determining the DRG relative weights, we assumed that 21.5 percent of coronary stent cases (those with code 36.06) from DRGs 516 and 517 would be reassigned to new DRGs 526 and 527 (with code 36.07), and the charges of these cases would be increased $3,996 per case, to approximate the higher charges associated with the drug-eluting stents in DRGs 526 and 527. The relative weights for DRGs 516 and 517 are calculated based on the charges of the cases estimated to remain in these two DRGs.

We note that this unprecedented approach is in response to the unique circumstances surrounding the potential breakthrough nature of this technology. We anticipate that the vast majority of new technologies in the future will continue to be routinely incorporated into the existing DRGs.

New DRG 526 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With AMI) will have the following principal diagnoses:

- 410.01, Acute myocardial infarction, anterolateral wall, initial episode of care.
- 410.11, Acute myocardial infarction, other anterior wall, initial episode of care.
- 410.21, Acute myocardial infarction, inferolateral wall, initial episode of care.
- 410.31, Acute myocardial infarction, inferoposterior wall, initial episode of care.
- 410.41, Acute myocardial infarction, inferior wall, initial episode of care.
- 410.51, Acute myocardial infarction, other lateral wall, initial episode of care.
- 410.61, True posterior wall infarction, initial episode of care.
- 410.71, Subendocardial infarction, initial episode of care.
- 410.81, Acute myocardial infarction of other specified sites, initial episode of care.
- 410.91, Acute myocardial infarction, unspecified site, initial episode of care.

And operating room procedures:

- 35.96, Percutaneous valvuloplasty.
- 36.01, Single vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy without mention of thrombolytic agent.
- 36.02, Single vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy with mention of thrombolytic agent.
- 36.05, Multiple vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy performed during the same operation, with or without mention of thrombolytic agent.
- 36.09, Other removal of coronary artery obstruction.
- 37.34, Catheter ablation of lesion or tissues of heart.

Or nonoperating room procedures:

- 37.26, Cardiac electrophysiologic stimulation and recording studies.
- 37.27, Cardiac mapping.

And nonoperating room procedure:

- 36.07, Insertion of drug-eluting coronary artery stent(s).

The principal diagnosis will consist of any principal diagnosis in MDC 5 except AMI:

- 410.01, Acute myocardial infarction, anterolateral wall, initial episode of care.
- 410.11, Acute myocardial infarction, other anterior wall, initial episode of care.
- 410.21, Acute myocardial infarction, inferolateral wall, initial episode of care.
- 410.31, Acute myocardial infarction, inferoposterior wall, initial episode of care.
- 410.41, Acute myocardial infarction, inferior wall, initial episode of care.
- 410.51, Acute myocardial infarction, other lateral wall, initial episode of care.
- 410.61, True posterior wall infarction, initial episode of care.
- 410.71, Subendocardial infarction, initial episode of care.
- 410.81, Acute myocardial infarction of other specified sites, initial episode of care.
- 410.91, Acute myocardial infarction, unspecified site, initial episode of care.
- And operating room procedures:
- 35.96, Percutaneous valvuloplasty.
- 36.01, Single vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy without mention of thrombolytic agent.
- 36.02, Single vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy with mention of thrombolytic agent
- 36.05, Multiple vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy performed during the same operation, with or without mention of thrombolytic agent
- 36.09, Other removal of coronary artery obstruction
- 37.34, Catheter ablation of lesion or tissues of heart

Or nonoperating room procedures:

- 37.26, Cardiac electrophysiologic stimulation and recording studies
- 37.27, Cardiac mapping

And nonoperating room procedure:

- 36.07, Insertion of drug-eluting coronary artery stent(s).

Comment: One commenter expressed concern that this technology will be used to treat lesions that are not clinically indicated. This commenter suggested that there should be clear language stating that drug-eluting stents should only be used in patients who are symptomatic from coronary artery disease as documented by noninvasive stress tests and imaging to locate the ischemia.

Response: We appreciate the commenter's concern that this new technology be used only where it is clinically indicated. We note that our treatment of this technology should in no way be construed to circumvent the ongoing FDA review. We expect that the technology, if approved, would be used in accordance with any labeling guidelines issued by the FDA, and we reserve the right to evaluate the need for Medicare coverage limitations or restrictions in the future.

Comment: One commenter applauded our recognition of the potential advance in peripheral vascular care by creating a code for noncoronary artery stents, code 00.55 (Insertion of drug-eluting noncoronary artery stent(s)). However, the commenter indicated it could not discern from Table 6B (67 FR 31630) the DRG to which code 00.55 was assigned.

Response: Our usual practice is to assign a new code to the DRG to which the predecessor code had been assigned. For example, in 1995, when we added additional fourth digits to 60.2 (Transurethral prostatectomy) and created 60.21 (Transurethral (ultrasound) guided laser induced prostatectomy (TULIP)) and 60.29 (Other Transurethral prostatectomy), we assigned the two new codes to the DRGs in which 60.2 had been located. (In version 12.0 of the GROUPER, those DRGs were 306 and 307 and DRG 336 and 337; the two newer codes continue to be assigned to the same DRGs today.) We have followed this precedent with code 00.55, which is patterned after code 39.90 (Insertion of non-coronary artery stent or stents). Code 39.90 is not a code recognized by the GROUPER software as a procedure code that causes DRG assignment, and therefore it is not assigned to a DRG or DRGs by itself. The GROUPER will recognize the main procedure in which a stent is inserted in order to make the DRG assignment for that case. We recognize that insertion of stents in noncoronary vessels has the potential to occur in many MDCs and DRGs. We will monitor the new stent code in noncoronary vessels in our MedPAR data to determine if the DRG placement in which it is reported is appropriate.

g. Cardiac Resynchronization Therapy

Cardiac resynchronization therapy for heart failure provides strategic electrical stimulation to the right atrium, right ventricle, and left ventricle, in order to coordinate ventricular contractions and improve cardiac output. This therapy includes cardiac resynchronization therapy pacemakers (CRT–P) and cardiac resynchronization therapy defibrillators (CRT–D). While similar to conventional pacemakers and internal cardioverter-defibrillators, cardiac resynchronization therapy is different because it requires the implantation of a special electrode within the coronary vein, so that it can be attached to the exterior wall of the left ventricle.

We received a recommendation that we assign implantation of CRT–D (code 00.51, effective October 1, 2002) to either DRG 104 (Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization) or DRG 514 (Cardiac Defibrillator Implant With Cardiac Catheterization). Currently, defibrillator cases are assigned to either DRG 514 (Cardiac Defibrillator Implant With Cardiac Catheterization) or DRG 515 (Cardiac Defibrillator Implant Without Cardiac Catheterization). DRG 514 has a higher relative weight than DRG 515. The manufacturer argued that the change should be made because the current DRG structure for cardioverter-defibrillator implants does not recognize the significant amount of additional surgical resources required for cases involving patients with heart failure.

The recommendation also supported assigning new code 00.50 (Implantation of cardiac resynchronization pacemaker without mention of defibrillation, total system [CRT–P]) to DRG 115 (Permanent Cardiac Pacemaker Implantation With AMI, Heart Failure, or Shock, or AICD Lead or Generator Procedure). Currently, pacemaker implantation procedures are assigned to either DRG 115 or DRG 116 (Other Permanent Cardiac Pacemaker Implant). DRG 115 has the higher relative weight. Because DRG 115 recognizes patients with heart failure, the manufacturer believed CRT–P cases would be appropriately classified to DRG 115.

We proposed to assign code 00.51 to DRG 514 or 515 and to assign code 00.50 to DRG 115 and 116. However, we solicited comments on these proposed DRG assignments and indicated that we would carefully consider any relevant evidence about the clinical efficacy and costs of this technology.

Comment: Numerous commenters responded to our statement that we would further consider evidence on the costs and clinical efficacy of the cardiac resynchronization technology. Commenters noted that, on average, patients with moderate to severe heart failure (New York Heart Class III/IV), for whom the CRT is indicated, are more physically compromised and need the support of additional personnel such as physical assistants and clinical heart failure coordinators. Data were submitted showing that heart failure cases have significantly longer average lengths of stay than average stays for other cases. These cases also have higher average charges (approximately $11,000 to $13,000 higher, according to one commenter). The commenters acknowledged that DRG 115 does specifically account for heart failure cases, but noted that DRGs 514 and 515 do not.

Commenters also argued there are additional costs associated with the additional surgical supplies required to perform these procedures (as well as the price differential of the new technology itself). Examples of supplies include a special left ventricular coronary sinus lead, a special pulse generator device, and a special electrical lead. One manufacturer estimated the incremental difference in the charges of the device and the additional surgical supplies to be $23,500.

Commenters further noted the additional surgical procedure time associated with CRTs. They noted that the implant procedure itself is much more complex than a conventional pacemaker or implanted cardioverter defibrillator, and generally requires additional staff, anesthesia, and other specialized services and supplies. The insertion of the left ventricular lead is estimated to require an additional 2 hours beyond a conventional procedure. Commenters pointed out that typically a venogram is required to navigate the coronary venous system. The additional time and resources were estimated to increase costs to the hospitals by $7,500.

Finally, commenters also cited data and anecdotal evidence to demonstrate the clinical benefits of this technology. The commenters noted that FDA approved CRT–D on May 2, 2002, which provides further evidence of the clinical efficacy of this technology. One commenter provided information to show that CRT–D improves peak oxygen uptake, translating to an increased ability to perform activities of daily living. Another commenter noted that pacing therapy offers the potential to increase blood pressure and heart rate.

On the basis of these higher costs and clinical improvements, these commenters generally recommended that CRT–Ds should be assigned to DRG 104. This DRG has a higher relative payment weight than either DRGs 514 or 515 (7.9615, compared to 6.3288 and 5.0380, respectively, based on the FY 2003 proposed DRG weights). One commenter suggested that if CRT–D cases are not assigned to DRG 104, they should only be assigned to DRG 514, not DRG 515. Several commenters suggested that CRT–Ps be assigned only to DRG 115, and not to DRG 116, since DRG 115 is the higher paying DRG. Other commenters suggested that all DRT–Ps be assigned to DRG 515 since DRG 515 pays more.

One commenter suggested that CRT–Ds are more clinically coherent to cases now assigned to DRG 104 based on: (1) The similarity of the diagnosis (for example, congestive heart failure); and (2) the similarities in clinical procedures used to implant a left ventricular lead and other cardiac catheterizations included in DRG 104. The commenter also suggested that the operating room preparation and procedure time for CRT–D cases was similar to that for other major cardiovascular procedures included in DRG 104, which supports the commenter's contention that CRT–Ds are more clinically consistent with DRG 104 than DRG 514 and 515.

Several commenters, including a national and a State hospital association, supported the assignment of new code 00.51 to DRG 514 or 515. Some commenters also supported the assignment of new code 00.50 to DRG 115 and DRG 116. The commenters added that cardiac resynchronization therapy is a new technology that recently received FDA approval and is still not widely used in hospitals in the United States. The commenters indicated that even though there is limited information at this time with regard to the clinical efficacy and costs of these devices, the technology seems to be similar to pacemakers and defibrillators, so the proposed DRG grouping is logical.

Response: We have carefully evaluated the information provided to us by the commenters. With respect to the cost data provided, we note that it is our previously stated preference to review actual data reflecting the total costs per case from patients treated with a particular new technology. Because the DRG payment is intended to cover all of the care provided during the course of an inpatient hospitalization, it is necessary to evaluate the impact a new technology may have on other aspects of patients' hospitalization. For example, many new technologies allow patients to be discharged sooner, actually reducing the total costs of the stay. While there is no indication that

this is the case with the CRT–D technology, we are unable to make an assessment based on the segregated data that were provided.

With respect to the suggestion that CRT–D cases should be assigned to DRG 104, we note that the DRG system groups cases that are similar clinically and in terms of costs. DRG 104 includes procedures performed on cardiac valves such as valve replacement and repair. Our clinical advisors disagree with the suggestion that the implantation of a CRT with or without defibrillation is clinically related or similar to procedures such as valve repair or replacement, which are assigned to DRG 104. We believe that, based on the nature and function of the devices, they are more appropriately classified as either pacemakers for the CRT–P or implantable cardioverter-defibrillators (ICDs) for the CRT–D devices. The additional lead is not, in our view, sufficient justification for classifying the CRT–Ds differently from all other debibrillators.

Furthermore, although chronic heart failure, for which these CRTs are used, is a common diagnosis, the etiology of the heart failure may vary significantly. Heart failure due to a faulty valve may be treated with valvuloplasty or valve replacement, and would be classified to DRG 104. On the other hand, heart failure due to ischemic events, such as a myocardial infarction, usually requires a completely different therapeutic approach involving other DRG assignments. Therefore, we do not believe it would be appropriate to classify cases receiving CRT–Ds to DRG 104.

With respect to the fall-back recommendation of the commenter that, if CRT–D cases are not assigned to DRG 104, they should all be assigned to DRG 514, we considered and rejected this suggestion. We note that a fundamental assumption underlying the DRGs is that the hospital has the responsibility for deciding what technology and process to employ in treating a particular type of patient. As hospitals in the aggregate make treatment decisions, these decisions are reflected in the DRG payment weights. This allows the payment rates to evolve in response to changing practice patterns.

The decision to treat CRT–D technology similarly to existing defibrillator technology is affected by our opinion that substantial improvement in health outcome benefits of adding the cardioverter-defibrillator component have not been fully established through clinical research. There are no published articles that have shown an improvement in survival from CRT. Although we appreciate the information provided by the commenters in this regard, we note there is not a significant body of evidence that CRT–D technology will supplant existing treatments for large numbers of patients. Because the DRG payment system is an average-based system wherein hospitals are expected to offset the higher costs of some cases with below-average costs in others, we anticipate that hospitals will be able to adequately finance this new technology as it is utilized. To the extent hospitals move to adopt this technology more widely over time, appropriate adjustments will be reflected in the DRG weights.

With respect to the recommendation that all CRT–P cases be assigned to DRG 115, CRT–Ps are inserted into patients with congestive heart failure. Therefore, when the code for CRT–P is reported in a patient with congestive heart failure, the case will be assigned to DRG 115. Only if the CRT–P were inserted in a patient who does not have congestive heart failure would the case be assigned to DRG 116. Since all the commenters agree that only patients with congestive heart failure would be candidates for the CRT–P, the end result will be that all of these cases would be assigned to DRG 115 as the commenters recommended. With respect to the recommendation that all CRT–Ps be assigned to DRG 515, our response is the same as for rejecting the assignment of DRT–Ds to DRG 515. Assignment of CRT–Ps to DRG 515 is not clinically appropriate.

Accordingly, we are adopting as final our proposed classification of code 00.50 to DRGs 115 and 116, and code 00.51 to DRGs 514 and 515. These changes will be effective for discharges occurring on or after October 1, 2002.

Comment: Many commenters mentioned that when the CRT–Ds are inserted, a coronary sinus venogram is often performed. The commenters stated that a venogram is a procedure that is similar to an arteriogram, which is classified as a non-O.R. procedure that affects the DRG assignment in some cases. The commenters stated that the additional time and resources of the venogram for a CRT–D should be accounted for by assignment of these cases to DRG 104.

Response: Coronary arteriograms and angiocardiograms do effect the DRG assignment in some cases. Arteriograms and angiograms of other sites that are not of the heart do not affect the DRG assignment. Venograms are not currently on the list of non-O.R. procedures that affect the DRG assignment. While the commenters are not suggesting that we add venograms to the list of non-O.R. procedures that affect the DRG assignment, they are recommending that the comparison of venograms to angiocardiograms be used as a justification for assigning CRT–Ds to DRG 104. Our medical consultants advise us that venograms are not as difficult to perform as are the coronary arterigrams and angiocardiograms. Venograms also have fewer associated risks than coronary arterigrams and angiocardiograms. Therefore, we would not reclassify venograms and make them affect the DRG assignment. In short, we do not believe that the performance of a venogram is justification for moving CRT–Ds to DRG 104.

h. Hip and Knee Revisions

We received a request to consider assigning hip and knee revisions (codes 81.53 and 81.55) out of DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) because these revisions are significantly more resource intensive and costly than initial insertions of these joints.

We examined claims data and concluded that, while the charges for the hip and knee revision cases were somewhat higher than other cases within DRG 209, they do not support the establishment of a separate DRG.

Comment: Two commenters addressed this issue. One commenter stated that additional data review was needed to determine the variation in charges and length of stay to determine if this recommendation should be pursued. Another commenter stated that using charge data is incorrect. Hospitals are under increased pressure and scrutiny to keep their charges low and would not increase the charges of the revision prosthetic because it does not influence the amount of payment received. The commenter suggested that revisions of the hip and knee procedures should have their own DRG.

Response: Hospital charges have been the basis for recalibration of the DRG weights since FY 1986. Therefore, it is in the hospitals' best interest to submit accurate billing data. We utilize charge data in our analysis of the DRGs to ensure that each DRG contains patients with a similar pattern of resource intensity. To the extent that the markup of charges over cost varies from one particular device or procedure to another, the relative weights will be impacted. However, due to the relativity of the DRG weights, a low markup associated with one device or procedure will be offset by relatively higher markups associated with another device or procedure, leading to higher relative weights, and thus higher payments, for the latter device or procedure.

i. Multiple Level Spinal Fusions

We received correspondence suggesting that we create new spinal fusion DRGs that differentiate by the number of discs that are fused in a spinal fusion. The correspondents indicated that the existing ICD–9–CM codes do not identify the number of discs that are fused. Codes were modified for FY 2002 to clearly differentiate between fusions and refusions, and new codes were created for the insertion of interbody spinal fusion device (84.51), 360 degree spinal fusion, single incision approach (81.61), and the insertion of recombinant bone morphogenetic protein (84.52) (66 FR 39841 through 39844).

ICD–9–CM codes have not historically been used to differentiate among cases by the number of repairs or manipulations performed in the course of a single procedure. However, we explored the possibility of creating codes to differentiate cases by the number of discs fused during a spinal fusion procedure at the April 18 and 19, 2002 meetings of the ICD–9–CM Coordination and Maintenance Committee. Because the topic proved to be quite challenging and will require additional discussion, the Committee will consider it further at its scheduled December 5 and 6, 2002 meeting.

We also note that DRGs generally do not segregate cases based on the number of repairs or devices that occur in the course of a single procedure. For instance, DRGs are not split based on the number of vessels bypassed in cardiac surgery, nor are they split based on the number of cardiac valves repaired. Therefore, we did not propose DRG changes for multiple level spinal fusions in the May 9, 2002 proposed rule.

Comment: Commenters representing national and state hospital associations supported the proposal to not make DRG changes for multiple level spinal fusions at this time. The commenters agreed that ICD–9–CM historically has not been used to differentiate among cases by the number of repairs or manipulations performed during a single procedure. Also, the commenters wrote that developing a coding methodology for multiple level spinal fusions will require careful consideration because it will be introducing a new concept into ICD–9–CM coding. The commenters offered to work with CMS to examine whether such a methodology could be developed in the future.

One commenter urged CMS to carefully examine the issue of providing separate codes and payment for multiple level spinal procedures. The commenter stated that increased costs were incurred in this type of surgery and may warrant recognition within the DRGs.

Response: We appreciate the comments on what has evolved as a challenging coding issue. We look forward to working with the commenter and other groups as we attempt to develop an efficient way to capture multilevel spinal fusions. The topic will be discussed at the next meeting of the ICD–9–CM Coordination and Maintenance Committee, which will be held on December 5 and 6, 2002. The agenda for this meeting will be posted in November 2002 at: *www.cms.hhs.gov/medicare/icd9cm.asp.* Once new codes are developed, we will evaluate the DRG assignments.

j. Open Wound of the Hand

We received a recommendation that we move code 882.0 (Open Wound of Hand Except Finger(s) Alone Without Mention of Complication) from its current location in MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast) under DRGs 280 through 282 (Trauma to the Skin, Subcutaneous Tissue and Breast Age >17 with CC, Age >17 without CC, and Age 0–17, respectively) into MDC 21 (Injuries, Poisonings and Toxic Effects of Drugs) under DRGs 444 through 446 (Traumatic Injury Age >17 with CC, Age >17 without CC, and Age 0–17, respectively).

In examining our data, we found relatively few cases with code 882.0. These cases had charges that were less than the average charges for DRGs to which they are currently assigned. The data do not support a DRG change. Our medical consultants also believe that the cases are appropriately assigned to DRGs 280 through 282.

We received comments in support on our proposed decision that the current DRG assignments for code 882.0 are appropriate. Accordingly, in this final rule we are not making any modifications of the DRG assignments for cases with code 882.0 at this time.

k. Cavernous Nerve Stimulation

As discussed in the August 1, 2001 final rule (66 FR 39845), we reviewed data in MDC 12 (Diseases and Disorders of the Male Reproductive System) to look specifically for code 89.58 (Plethysmogram) in DRG 334 (Major Male Pelvic Procedures with CC) and DRG 335 (Major Male Pelvic Procedures without CC).

Our data show that very few (six) of these procedures were reported on FY 2001 claims. It is not clear whether the small number reflects the fact that the procedure is not being performed, the ICD–9–CM code is not recorded, or the code is recorded but it is not in the top six procedures being performed. However, in all six cases where this procedure was performed, it occurred in conjunction with radical prostatectomy, so we are confident that these cases are consistent with the DRGs to which they have been assigned. Therefore, we did not propose any DRG assignment changes to procedures code 89.58 or any changes to DRGs 334 and 335.

We received one comment in support of our proposal not to change the DRG assignment of code 89.58 or DRGs 334 and 335. Accordingly, in the final rule we are making no changes to DRGs 334 and 335 with regard to procedure code 88.58. We anticipate that procedure code 89.58 will be performed in conjunction with radical prostastectomy, which is an operative code(s) describing the major surgical procedure.

1. Additional Issues Raised by Comments

We received a number of comments on additional specific DRG assignment issues that were not raised in the proposed rule. We are not responding to them individually here because they were not raised in the proposed rule. We will be considering each issue raised for consideration in the FY 2004 DRG reclassifications. We also note that we previously described a process for submission of non-MedPAR data for consideration in evaluating the DRG assignment issue (64 FR 41499).

C. Recalibration of DRG Weights

We are using the same basic methodology for the FY 2003 recalibration as we did for FY 2002 (August 1, 2001 final rule (66 FR 39828)). That is, we recalibrate the weights based on charge data for Medicare discharges. For the proposed rule, we used the most current charge information available, the FY 2001 MedPAR file. (For the FY 2002 recalibration, we used the FY 2000 MedPAR file.) The MedPAR file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills.

The final recalibrated DRG relative weights are constructed from the FY 2001 MedPAR data, which include discharges occurring between October 1, 2000 and September 30, 2001, based on bills received by CMS through March 31, 2002, from all hospitals subject to the acute care hospital inpatient prospective payment system and short-term acute care hospitals in waiver

States. The FY 2001 MedPAR file includes data for approximately 11,483,663 Medicare discharges. The data include hospitals that subsequently became CAHs, although no data are included for hospitals after the point they are certified as CAHs.

The methodology used to calculate the DRG relative weights from the FY 2001 MedPAR file is as follows:

- To the extent possible, all the claims were regrouped using the DRG classification revisions discussed in section II.B. of this preamble.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG. A transfer case is counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases. That is, transfer cases paid under the transfer methodology equal to half of what the case would receive as a nontransfer would be counted as 0.5 of a total case.
- We then eliminated statistical outliers, using the same criteria used in computing the current weights. That is, all cases that are outside of 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG are eliminated.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight. (See section II.B.14.f. of this preamble for a discussion of the special adjustment used in calculating the FY 2003 DRG relative weights for DRGs 526 and 527.)
- We established the relative weight for heart and heart-lung, liver, and lung transplants (DRGs 103, 480, and 495) in a manner consistent with the methodology for all other DRGs except that the transplant cases that were used to establish the weights were limited to those Medicare-approved heart, heart-lung, liver, and lung transplant centers that have cases in the FY 1999 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Acquisition costs for kidney, heart, heart-lung, liver, lung, and pancreas transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are concentrated in specific DRGs: DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant); DRG 480 (Liver Transplant); DRG 495 (Lung Transplant); and DRGs 512 (Simultaneous Pancreas/Kidney Transplant) and 513 (Pancreas Transplant). Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to exclude them from the relative weights for these DRGs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We used that same case threshold in recalibrating the DRG weights for FY 2003. Using the FY 2001 MedPAR data set, there are 41 DRGs that contain fewer than 10 cases. We computed the weights for these 41 low-volume DRGs by adjusting the FY 2002 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

The new weights are normalized by an adjustment factor (1.43889) so that the average case weight after recalibration is equal to the average case weight before recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the prospective payment system.

We did not receive any comments on DRG recalibration.

Section 1886(d)(4)(C)(iii) of the Act requires that, beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years and as discussed in section II.A.4.a. of the Addendum to this final rule, we make a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

D. Add-On Payments for New Services and Technologies

1. Background

Section 533(b) of Public Law 106–554 amended section 1886(d)(5) of the Act to add subparagraphs (K) and (L) to establish a process of identifying and ensuring adequate payment for new medical services and technologies under Medicare. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that the process must apply to a new medical service or technology if, ''based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges * * * is inadequate.'' Section 1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered ''new'' if it meets criteria established by the Secretary (after notice and opportunity for public comment).

In the September 7, 2001 final rule (66 FR 46902), we established that a new technology would be an appropriate candidate for an additional payment when it represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries (§ 412.87(b)(1)).

We also established that new technologies meeting this clinical definition must be demonstrated to be inadequately paid otherwise under the DRG system to receive special payment treatment (§ 412.87(b)(3)). To assess whether technologies would be inadequately paid under the DRGs, we established this threshold at one standard deviation beyond the geometric mean standardized charge for all cases in the DRGs to which the new technology is assigned (or the case-weighted average of all relevant DRGs, if the new technology occurs in many different DRGs) (§ 412.87(b)(3)).

Table 10 in the Addendum of this final rule lists the qualifying criteria by DRG based on the discharge data that we are using to calculate the FY 2003 DRG weights. These thresholds will be used to evaluate applicants for new technology add-on payments during FY 2004 (beginning October 1, 2003). Similar to the timetable for applying for new technology add-on payments during FY 2003, we are requiring applicants for FY 2004 to submit a significant sample of the data no later than early October 2002. The complete request also must include a full

description of the clinical applications of the technology and the results of any clinical evaluations demonstrating that the new technology represents a substantial clinical improvement. Subsequently, we are requiring that a complete database be submitted no later than mid-December 2002.

Applications for consideration under this provision for FY 2004 should be sent to the following address: Centers for Medicare & Medicaid Services, c/o Inpatient New Technology Applications, Mail Stop C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244.

In addition to the clinical and cost criteria, we established that, in order to qualify for the special payment treatment, a specific technology must be ''new'' under the requirements of § 412.87(b)(2) of our regulations. The statutory provision contemplated the special payment treatment for new technologies until such time as data are available to reflect the cost of the technology in the DRG weights through recalibration (no less than 2 years and no more than 3 years). There is a lag of 2 to 3 years from the point a new technology is first introduced on the market and when data reflecting the use of the technology are used to calculate the DRG weights. For example, data from discharges occurring during FY 2001 are used to calculate the FY 2003 DRG weights in this final rule.

Technology may be considered ''new'' for purposes of this provision within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the technology. After CMS has recalibrated the DRGs to reflect the costs of an otherwise new technology, the special add-on payment for new technology will cease (§ 412.87(b)(2)). For example, an approved new technology that received Food and Drug Administration (FDA) approval in October 2001 would be eligible to receive add-on payments as a new technology until FY 2004 (discharges occurring before October 1, 2003), when data reflecting the costs of the technology would be used to recalibrate the DRG weights. Because the FY 2004 DRG weights will be calculated using FY 2002 MedPAR data, the costs of such a new technology would be reflected in the FY 2004 DRG weights.

In the September 7, 2001 final rule, we established that Medicare would provide higher payments for cases with higher costs involving identified new technologies, while preserving some of the incentives under the average-based payment system. The payment mechanism is based on the cost to hospitals for the new technology. Under § 412.88, Medicare would pay a marginal cost factor of 50 percent for the costs of the new technology in excess of the full DRG payment. If the actual costs of a new technology case exceed the DRG payment by more than the estimated costs of the new technology, Medicare payment would be limited to the DRG payment plus 50 percent of the estimated costs of the new technology.

The report language accompanying section 533 of Public Law 106–554 indicated Congressional intent that the Secretary implement the new mechanism on a budget neutral basis (H.R. Conf. Rept. No. 106–1033, 106th Cong., 2d Sess. at 897 (2000)). Section 1886(d)(4)(C)(iii) of the Act requires that the adjustments to annual DRG classifications and relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. Therefore, we account for projected payments under the new technology provision during the upcoming fiscal year at the same time we estimate the payment effect of changes to the DRG classifications and recalibration. The impact of additional payments under this provision would then be included in the budget neutrality factor, which is applied to the standardized amounts and the hospital-specific amounts.

Because any additional payments directed toward new technology under this provision must be offset to ensure budget neutrality, it is important to consider carefully the extent of this provision and ensure that only technologies representing substantial advances are recognized for additional payments. In that regard, we indicated that we will discuss in the annual proposed and final rules those technologies that were considered under this provision; our determination as to whether a particular new technology meets our criteria for a new technology; whether it is determined further that cases involving the new technology would be inadequately paid under the existing DRG payment; and any assumptions that went into the budget neutrality calculations related to additional payments for that new technology, including the expected number, distribution, and costs of these cases.

To balance appropriately Congress' intent to increase Medicare's payments for eligible new technologies with concern that the total size of those payments not result in significantly reduced payments for other cases, we set a target limit for estimated special payments for new technology under the provisions of section 533(b) of Public Law 106–554 at 1.0 percent of estimated total operating prospective payments.

If the target limit is exceeded, we would reduce the level of payments for approved technologies across the board, to ensure estimated payments do not exceed the limit. Using this approach, all cases involving approved new technologies that would otherwise receive additional payments would still receive special payments, albeit at a reduced amount. Although the marginal payment rate for individual technologies would be reduced, this would be offset by large overall payments to hospitals for new technologies under this provision.

Comment: Numerous commenters expressed concern that the method by which payments are made—in a budget neutral manner—reduces the amount of DRG payments for other cases. The commenters noted that shifting money around within the prospective payment system leaves hospitals without the additional money they need to ensure beneficiaries have access to the newest medical tests and treatments. Many of the commenters believed that reducing payments for other services in order to increase payments for new technology is inappropriate, as the costs associated with all other inpatient procedures are not declining. The commenters noted that they will continue to urge Congress to adopt an appropriate adjustment to hospital payments without redistributing payments from elsewhere in the system.

Some commenters also wrote that the new technologies listed in the proposed rule are worthy of additional funding, but, since budget neutrality would reduce payments for all other inpatient procedures, even though costs for these procedures are not declining, the applications should not be approved. However, if the applications are approved, the commenters stressed the need to maintain the requirement that no more than 1 percent of total acute inpatient prospective payments may be used for new technology payments. Furthermore, if actual total add-on payments were less than estimated in calculating the budget neutrality adjustment, the commenters argued that unspent funds should be restored to the standardized amount.

Response: As stated above, the Congressional Report language accompanying section 533 of Public Law 106–554 clearly indicated Congress' intent that this provision is to be implemented in a budget neutral manner. Therefore, the commenters are correct that Congress is the appropriate body to consider concerns about the budget neutrality of this provision. We

also agree with the commenters about the need to limit the total payments made under this provision. In the September 7, 2001 final rule, we established a target limit of 1 percent of total acute inpatient prospective payment system payments for new technology. This target is intended to limit the redistributional impact of these higher payments for new technology relative to payments for other services.

Although our estimates are influenced by past experience, it has been our longstanding practice not to adjust our budget neutrality calculations retroactively on the basis of actual payments. We note that hospitals may either benefit or lose in any given year, depending on whether we underestimate or overestimate the budget neutrality factor. We would note that, in years when hospitals benefited from an underestimate of the budget neutrality factor, we did not recoup any payments resulting from the underestimate.

Comment: Some commenters criticized our implementation of the add-on payment provision for new technology. They claimed that the criteria we set make it impossible for technologies to qualify for add-on payments and suggest that many companies did not apply for new technology add-on payments because the threshold and other criteria were set so high. As proof, the commenters pointed to the small number of applications we received for new technology add-on payments for FY 2003, and to the apparent denial of all applicants. The commenters argued that our criteria operate to nullify the effect of the provision and, therefore, go against Congress' intent.

Response: Unlike the commenters, we believe the limited number of applications lends support to the appropriateness of the criteria. It was our intention to implement this provision without fundamentally disrupting the prospective payment system. A substantial number of cases receiving extra cost-based payments, (or substantial disaggregation of the DRGs into smaller units of payment) would undermine the efficiency incentives of the DRG payment system. This system, is founded on the theory that, by paying for patients with similar clinical characteristics based on the average resources needed to treat those patients, the system creates an incentive for physicians and hospitals to evaluate the most appropriate treatment approach for an individual patient, knowing that the payment to the hospital will, on average, reflect the average resources utilized across all patients in the DRG. Add-on payments for specific new technologies influence the financial incentives faced by the physician and the hospital, and, because these payments are implemented in a budget neutral manner, they impact the average payments for all DRGs.

While we recognize Congress' intent that Medicare beneficiaries have faster access to new technologies that may be introduced more slowly otherwise due to payment concerns, we believe Congress also did not intend to fundamentally disrupt the incentives of the prospective payment system. We will continue to carefully evaluate whether our criteria appropriately balance these two objectives.

Comment: Many commenters repeated objections to policies proposed in the May 4, 2001 proposed rule (66 FR 22646). These comments are listed here.

Several commenters argued that the one standard deviation threshold was too high for most new technologies to qualify. Commenters also wrote that the substantial clinical improvement criterion should be removed, and that the 50-percent pass-through payment does not adequately reimburse hospitals for the cost of new technologies. Many commenters suggested that we use the 80-percent standard that we use for outlier thresholds.

One commenter objected to our requirement of a ''significant sample'' of ''verifiable'' external data. This commenter wrote that any economic data required should be reasonably derived from the clinical trials conducted in conjunction with submissions to the FDA. In addition, our data requirements should not be overly burdensome and should recognize the difficulties faced by hospitals, such as compliance with patient confidentiality regulations.

Some commenters suggested that we incorporate new technologies directly into the DRG system and adjust the weights to reflect the increased costs of the item(s) as data become available. They argued that this method would be more consistent with the fundamental structure of the acute care hospital inpatient prospective payment system and would avoid the complexity of coding and billing for new technology cases.

Some commenters suggested that the ICD–9–CM Coding System cannot continue to be expanded to create new codes to identify new technologies in the long term, and the ICD–10–Procedure Coding System (ICD–10–PCS) would be an appropriate long-term solution. One commenter, a national hospital association, referred to ICD–10–PCS as ''the system of choice with appropriate attention given to implementation, education and system related issues.'' This commenter recommended that the approval process be revised to include a requirement that the applicant must barcode each item for ease of hospital reporting and billing, based on Universal Product Numbers.

Response: We discussed our positions on each of these issues in detail in the September 7, 2001 final rule (66 FR 46905). We appreciate the interest of the many stakeholders in ensuring that Medicare beneficiaries have full access to improvements in medical technology. Our rationales for these policies have not changed since we discussed them in that final rule, and we did not propose changes to these policies in the May 9, 2002 proposed rule. Therefore, readers are referred to the September 7, 2001 final rule for our responses to these comments. However, we will continue to assess each of these policies as we gain more experience with this provision, and would appreciate the commenters' continued input.

Comment: MedPAC agreed with the approach that we have taken in implementing this provision. MedPAC stated that our approach is ''a reasonable compromise between the need to provide quick access to important new technologies for Medicare beneficiaries and not spending more than necessary.''

Response: We appreciate the supportive comments submitted by MedPAC.

Comment: In conjunction with concern regarding overall payment decreases as a result of the requirement that add-on payments for new technology be budget neutral, several other commenters indicated that they agreed with our proposed denial of all of the new technology applications.

Response: We want to clarify the misunderstanding expressed by some new technology applicants that we proposed to deny all of the applications. In the May 9, 2002 proposed rule, we stated that, for two of the applicants, Xigris™ and the InFUSE™ Bone Graft/LT-CAGE™ Lumbar Tapered Fusion Device, we were withholding a final determination on whether these technologies represented a substantial clinical improvement or met the cost threshold until the final rule. We did propose to deny the other two applicants, Zyvox™ and Renew™ Radio Frequency Spinal Cord Stimulation Therapy.

Comment: One commenter believed that the cost threshold for a new technology to qualify for add-on payments is too high, but also expressed

concern that recent proposed legislation, which would establish that the cost of new technology must exceed the lesser of the current threshold or 50 percent above the standardized amount (about $2,100), was too low. This commenter urged us to amend our regulations to continue to allow the threshold to vary by DRG (currently, the threshold is based on the DRG's geometric mean charge plus the DRG's standard deviation of charges), but at a lower level than at present.

However, another commenter argued in favor of the alternative lower threshold. This commenter wrote that the current cost threshold was the primary reason that many technology manufacturers determined that submission of an application for an add-on payment would be fruitless.

Response: We agree with the commenter that the alternative threshold proposed in the legislation is too low. Reducing the threshold to such an extent would lead to many more technologies qualifying for add-on payments, which would be contrary to the bundling theory of the DRG system and would be inflationary. Under these lower thresholds, technology sponsors would have a strong incentive to establish prices for otherwise low-cost technologies at marginally higher levels that would meet this minimal threshold. In contrast, market forces prevent otherwise low-cost technologies being priced at a level sufficient to meet our present, higher threshold. Even though the add-on payments are budget neutral, this price inflation would eventually be reflected in the market basket. On the other hand, the current thresholds greatly limit inflationary pressures by targeting technologies that have extraordinarily high costs. However, we will continue to assess the adequacy of our current criteria as we continue to gain experience implementing the provision for add-on payments for new technologies.

Comment: One commenter argued that the evaluation of an application for the substantial clinical improvement criteria should focus on the potential for the new technology to result in a substantial improvement over currently covered therapies. The commenter noted that very few medical devices are approved by the FDA on the basis of clinical trials that directly compare the new technology to other Medicare-covered alternatives. Data demonstrating a clear advantage in clinical outcomes are often not available until several years after FDA approval.

The commenter believed this approach would be beneficial to CMS, noting that the current process suggests a coverage-type analysis, potentially limiting CMS' ability to undertake any later coverage review after a substantial improvement determination is made. The commenter added that denying a request on the basis that a technology does not represent a substantial improvement could lead local Medicare contractors to restrict coverage based upon such a denial.

Response: We disagree that data needed to evaluate whether new devices are a substantial improvement over current therapies are unavailable until years after the technology is introduced. Our experience evaluating the applications discussed below, as well as under the outpatient prospective payment system pass-through policy, demonstrates that the sponsors of new technologies generally do collect data that can be used to assess whether a new technology is a substantial improvement over previously available technologies. Further, we believe it would be difficult, if not infeasible, to assess objectively the validity of an unsupported claim about potential outcomes. Rather, we believe it is appropriate and reasonable to expect applicants to present verifiable data demonstrating a substantial improvement of any applicant new technology relative to available alternatives.

We also do not believe that denial of an application on the grounds that the new technology is not a substantial improvement over existing technologies would lead to Medicare's contractors denying coverage. The criteria for substantial improvement determinations are quite different from coverage determinations, and we do not believe our contractors are likely to confuse the two.

Comment: One commenter wrote that it would be inappropriate to apply the budget neutrality adjustment to the hospital-specific payments to sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs). The commenter's argument appears to be based on the presumption that the add-on payments would not be available to hospitals paid using the hospital-specific rates.

Response: The commenter has correctly pointed out that we did not address whether add-on payments would be made to SCHs or MDHs paid on the basis of their hospital-specific amount in accordance with § 412.92(d) and § 412.108(c), respectively. We believe these additional payments for new technologies should be available to SCHs and MDHs paid on the basis of their hospital-specific amounts. These hospitals' payments under the hospital-specific amount methodology are adjusted by the DRG weight for each discharge. Because the costs of new technology would not be reflected in the base years used to calculate the applicable hospital-specific amounts, it is appropriate to provide for these hospitals to receive the add-on payments under this provision. Therefore, we are amending § 412.88(a)(1) to reflect this oversight.

Because SCHs and MDHs will be eligible to receive add-on payments in addition to their hospital-specific amounts, it is also appropriate to apply the applicable budget neutrality adjustments to the hospital-specific amounts.

Comment: Some commenters requested a payment calculation, showing that the add-on payment is made before the outlier adjustment. The commenters also were confused about the add-on payments in transfer situations. They wanted clarification on whether the transferring hospital would get the full add-on payment or if it would receive a prorated payment, and requested an example.

In addition, one commenter asked whether payments for indirect medical education (IME) or the disproportionate share hospital (DSH) adjustment are included in the ''DRG payment amount'' that is compared against costs to determine whether an individual case qualifies for the add-on payment. The commenter argued that if the add-on payment amount is calculated before outlier payments, it would logically follow that they would also be calculated before IME and DSH payments.

Response: The commenters are correct that the add-on payment is made prior to calculating whether the case qualifies for outlier payments (see § 412.80(a)(3)). In response to the request for a payment example, consider a new technology estimated to cost $3,000, in a DRG that pays $20,000. A hospital submits three claims for cases involving this new technology. After applying the hospital's cost-to-charge ratio, it is determined that the costs of these three cases are $19,000, $22,000, and $25,000. Under the proposed approach, Medicare would pay $20,000 (the DRG payment, including any IME or DSH payments) for the first claim. For the second claim, Medicare would pay one half of the amount by which the costs of the case exceed the DRG payment, up to the estimated cost of the new technology, or $21,000 ($20,000 plus one half of the amount by which costs of the case exceed the standard DRG payment). For the third claim, Medicare would pay $21,500 ($20,000 plus one half of the

total estimated costs of the new technology). In the event the hospital had a fourth case with extraordinarily high costs, the fixed-loss outlier threshold would be applied to the total DRG payment plus the add-on payment for new technology ($21,500), for comparison with the actual costs to determine whether the case would qualify for outlier payments.

With respect to the comment requesting clarification regarding the amount of the add-on payment made to a transferring hospital where the new technology eligible for add-on payments is provided prior to the transfer, the amount of the new technology add-on payment is not adjusted, but is paid up to 50 percent of the full cost of the new technology. This is appropriate because the hospital is likely to incur the full cost of the new technology when it is used. We are amending § 412.88(a)(1) to reflect this clarification.

With respect to whether IME and DSH payments are excluded from the comparison between the full DRG payment for the case and the costs for purposes of computing the add-on payment, § 412.88(a)(1) states that the full DRG payment ''includes indirect medical education and disproportionate share.'' This amount is then compared to the costs of the discharge to compute the amount of the add-on payment § 412.88(a).

Comment: One commenter, representing a national hospital association, recommended against approving new technologies with very limited utilization because these technologies should already be receiving additional funds as outlier cases, and the added administrative burden of including these items negates any benefit. This commenter also suggested that we limit the number of applications that can be approved by setting a minimum of $30 million in projected payments for each new technology.

This commenter argued that this limitation would reflect the added burden and administrative expense for hospitals associated with each additional new technology item that is approved. The commenter stated that training and operational and behavioral changes in response to specific coding requirements were examples of such additional costs.

Response: We believe the incremental costs to hospitals associated with this provision should be minimal. Specifically, the additional payments are triggered by the presence of an ICD–9–CM code on the bill, information already required to process the claim for normal DRG payment. Accordingly, there should be little need for training or other operational changes in response to the approval of a new technology for add-on payments.

Comment: Commenters requested further guidance for future applications.

Response: We are developing more detailed instructions for applicants, based on our experience in processing the FY 2003 applications. In the meantime, individuals interested in obtaining more information about the application process should call the Division of Acute Care at (410) 786–4548.

2. Applicants for FY 2003

We received five applications for new technologies to be designated eligible for inpatient add-on payments for new technology. One of these applications was subsequently withdrawn. In the proposed rule, we proposed that two of the applicants, Zyvox™ and Renew™ Radio Frequency Spinal Cord Stimulation Therapy, did not meet our criteria. We withheld a final determination on two other applicants, Xigris™ and the InFUSE™ Bone Graft/LT-CAGE™ Lumbar Tapered Fusion Device, pending further review to determine whether they met the substantial clinical improvement criteria.

Comment: A few commenters noted that, according to the final rule last year (66 FR 46914), we indicated we would propose our determination regarding new technology applications in the proposed rule. The public would then have the opportunity to comment on the proposed determinations. Because the FY 2003 proposed rule did not include specific proposed determinations for two technologies, the commenters argued that we did not give the public and the provider community an appropriate notice and comment period before the decisions take effect on October 1, 2002. These commenters urged us to allow for additional public comments on our final decisions announced in this final rule.

Response: We presented the results of our analysis of the available data in the May 9, 2002 proposed rule, including the budget neutrality implications, to provide an opportunity for those interested to submit specific comments on the applications. In fact, we did receive comments on specific aspects of the applications, as noted below. In addition, we clearly indicated in the proposed rule we were continuing to evaluate Xigris™ and the InFUSE™ Bone Graft/LT-CAGE™ Lumbar Tapered Fusion Device for possible approval in the final rule (67 FR 31428 and 31429). Therefore, we believe interested parties had sufficient information to evaluate our proposed decisions and to provide informed comments. For these reasons, we are not extending the period for providing public comment on the decisions on applicants announced below.

We also noted in the May 9 proposed rule that, due to the very limited timeframe between enactment of this provision, its implementation through the final rule, and the deadlines to submit applications for consideration for FY 2003, it was necessary to be more flexible this first year in working with the applicants to ensure that they were given every opportunity to demonstrate that their new technology qualified for add-on payments. Insofar as possible, we intend in the future to announce our proposed determinations in the annual proposed rule updating the acute care hospital inpatient prospective payment system.

a. Drotrecogin Alfa (Activated)—Xigris™

Eli Lilly and Company (Lilly) developed drotrecogin alfa (activated), trade name Xigris™, as a new technology and submitted an application to us for consideration under the new technology add-on provision. Xigris™ is used to treat patients with severe sepsis.

According to the application—

''Approximately 750,000 cases of sepsis associated with acute organ dysfunction (severe sepsis) occur annually in the United States. The mortality rates associated with severe sepsis in the United States range from 28 percent to 50 percent and have remained essentially unchanged for several decades. Each year, 215,000 deaths are associated with severe sepsis; deaths after acute myocardial infarction occur at approximately an equal rate.''

Xigris™ is a biotechnology product that is a recombinant version of naturally occurring Activated Protein C (APC). APC is needed to ensure the control of inflammation and clotting in the blood vessels. In patients with severe sepsis, Protein C cannot be converted in sufficient quantities to the activated form. It appears that Xigris™ has the ability to bring blood clotting and inflammation back into balance and restore blood flow to the organs.

In support of its application, Lilly submitted data from the Phase III Protein C Worldwide Evaluation in Severe Sepsis (PROWESS) trial. According to Lilly, this was ''an international, multicenter, randomized, double-blind, placebo-controlled trial in which 1,690 patients with severe sepsis received either placebo (n = 840) or

drotrecogin alfa (activated) (n = 850).'' The results of the trial were published in an article in the March 8, 2001 edition of *The New England Journal of Medicine* (Bernard, G. R., Vincent, J. L., et. al., ''Efficacy and Safety of Recombinant Human Activated Protein C for Severe Sepsis,'' Vol. 344, No, 10, p. 699).

Xigris™ was approved by the FDA in November 2001. In its approval letter, the FDA wrote that this biologic ''is indicated for the reduction of mortality in adult patients with severe sepsis (sepsis associated with acute organ dysfunction) who have a high risk of death (for example, as determined by APACHE II [acute physiology and chronic health evaluation]).'' In the May 9, 2002, proposed rule, however, we indicated that we were unable to conclude, based on the published data, that Xigris™ represents an advance that substantially improves, relative to technology previously available, treatment for Medicare beneficiaries. Specifically, because the reduction in mortality in the published data was the result of a treatment effect in a relatively small number of patients and mortality was examined for only 28 days after treatment, we indicated that we planned to review unpublished data on all-cause mortality at the time of hospital discharge for all patients enrolled in the study.

Subsequent to the publication of the proposed rule, Lilly submitted additional data in response to our request. The major endpoint of the PROWESS study was a reported reduction in 28-day all-cause mortality of 6.1 percent. At the time the study ended, many of the participants were still hospitalized and whether they would ultimately recover was unknown. We requested data about those hospitalized patients to determine if the reported advantage in mortality from Xigris™ use persisted for all study participants. These data are now available and show an overall decrease in mortality for all patients, including patients over 65 years of age.

Therefore, we have concluded that, when used in accordance with the following FDA-listed indications and contraindications, Xigris™ meets the substantial improvement criteria for additional payment for new medical services and technologies under § 412.87(b)(1):

- Active internal bleeding;
- Recent (within 3 months) hemorrhagic stroke;
- Recent (within 2 months) intracranial or intraspinal surgery or severe head trauma;
- Trauma with an increased risk of like-threatening bleeding;
- Presence of an epidural catheter;
- Intracranial neoplasm or mass lesion or evidence of cerebral herniation.

Detailed bills were available for 604 of 705 patients in the United States in the PROWESS clinical trial (303 placebo patients and 301 treatment patients). In all, 83 hospitals submitted detailed bills. Of the 604 cases with detailed billing data, 274 were patients age 65 or older. The average total charge for these 274 cases, including the average standardized charge for the biological, was $86,184 (adjusted for inflation using the applicable hospital market baskets, as patients were enrolled in the trial from July 1998 through June 2000). The inflated average standardized charge of the biological only for these cases was $15,562.

Lilly also submitted detailed ICD–9–CM diagnosis and procedure codes for a subset of 157 of the 604 U.S. patients with billing data from the PROWESS trial. These data were not requested as part of the trial, but were sent in separately. Of these 157 patients, 82 were over 65 years of age. These 82 patients grouped into 23 DRGs. Approximately 75 percent of these 82 cases were in 5 DRGs: 29 percent were in DRG 475 (Respiratory System Diagnosis with Ventilator Support); 17 percent were in DRG 483 (Tracheostomy Except for Face, Mouth, and Neck Diagnoses); 15 percent were in DRG 416 (Septicemia Age>17); 7 percent were in DRG 415 (OR Procedure for Infectious and Parasitic Diseases); and 5 percent were in DRG 148 (Major Small and Large Bowel Procedures With CC).

Using the methodology described in the September 7, 2001 final rule (66 FR 46918), we calculated a case-weighted threshold based on the distribution of these 82 cases across 23 DRGs. In order to qualify for new technology payments based on these DRGs, the threshold would be $82,882 (compared to the average standardized charge of $86,184 noted above).

In the September 7, 2001 final rule, we stated that the data submitted must be of a sufficient sample size to demonstrate a significant likelihood that the sample mean approximates the true mean across all cases likely to receive the new technology. Using a standard statistical methodology for determining the needed (random) sample size based on the standard deviations of the DRGs identified in the trial as likely to include cases receiving Xigris™, we have determined that a random sample of 274 cases can be reasonably expected to produce an estimate within $3,500 of the true mean.[2] Of course, the data submitted do not represent a random sample of all cases in these DRGs across all hospitals.

The 274 case sample was for all U.S. patients over age 65 included in the PROWESS trial. In the September 7, 2001 final rule, we indicated our preference for using Medicare cases identifiable in our MedPAR database, although data from a trial without matching MedPAR data could be considered. We also indicated our intention to independently verify the data submitted.

We noted in the May 9, 2002 proposed rule (67 FR 31429) that, due to the passage of Public Law 106–554 in December 2000, and the publication of the final rule in September 2001, it was understandable that the data requirements that were included in the final rule in order to ensure that we would receive the information necessary to analyze applicants for new technology add-on payments were not accommodated in the design of the PROWESS trial. Therefore, in this case, it was necessary for CMS to work with Lilly to verify independently the data in order to determine whether Xigris™ represents a substantial clinical improvement.

After publication of the proposed rule, we analyzed our MedPAR data to develop a cohort group of patients in order to assess the validity of the charges reported for the patients in the PROWESS trial. Using the same methodology as Lilly, we were able to identify a cohort group of cases in the MedPAR data with similar criteria as the patients who were screened for the PROWESS trial and were discharged from the hospitals included in the trial. We calculated that the average total charges for these cases closely approximated the total charges that Lilly sent with its analysis. Based on this analysis, we have determined that the average standardized charges of $86,184 described above exceeds the cost threshold criteria of $82,882 for the DRGs involved. Therefore, we are approving Xigris™ for add-on payments under § 412.88, to be effective for FY 2003 and FY 2004.

Cases where Xigris™ is administered will be identified by use of the new ICD–9–CM procedure code 00.11 (Infusion of drotrecogin alfa (activated)). According to Lilly, ''(t)he net wholesale

[2] The formula is $n = 4\sigma^2/B^2$, where σ is the standard deviation of the population, and B is the bound on the error of the estimate (the range within which the sample means can reliably predict the population mean). See Statistics for Management and Economics, Fifth Edition, by Mendenhall, W., Reinmuth, J., Beaver, R., and Duhan, D.

price for drotrecogin alfa (activated) is $210 for a 5-milligram vial and $840 for a 20-milligram vial. The average cost for a one-time 96-hour course of therapy for an average adult patient is $6,800 (24μg/kg/hr for 96 hours for a 70kg person).'' Therefore, cases involving the administration of Xigris™ as identified by the presence of code 00.11 are eligible for additional payments of up to $3,400 (50 percent of the average cost of the drug).

For purposes of budget neutrality, we have estimated the additional payments that would be made under this provision during FY 2003. Lilly had estimated that, initially, 25,000 Medicare patients would receive Xigris™. However, Lilly's estimate does not fully reflect severe sepsis patients who may not have multiple organ failure, but for whom Xigris™ is indicated nonetheless due to APACHE II scores in the third and fourth quartiles. Therefore, for purposes of our budget neutrality estimates, we are projecting 50,000 Medicare patients will receive Xigris™ during FY 2003. We believe this projection reflects modest growth in FY 2003 from $35 million in sales reported by Lilly through February 2002 (since the drug was approved in November 2001). (At $6,800 per patient, $35 million in sales equates to just over 5,000 cases for the first 4 months since FDA approval.) We note that some analysts project sales of Xigris™ as high as approximately 100,000 cases annually. We believe our estimate reflects the potential for growth beyond the current usage since FDA approval in November 2001, and for the use of Xigris™ in treating patients without multiple organ failure for whom the drug is indicated but who were not included in Lilly's estimate.

If the maximum $3,400 add-on payment is made for all 50,000 of these patients, the total amount that would be paid for these cases would be an additional $170 million. However, comparing the total standardized charges for the 274 patients age 65 or older, we calculated that 56 percent had average standardized charges below the weighted average standardized charges for the 23 DRGs into which these cases were categorized. Therefore, assuming the costs for these cases would be below the payment received, these 56 percent of cases would not receive any additional payment. Therefore, for purposes of budget neutrality, we estimate the total payments likely to be made under this provision during FY 2003 for cases involving the administration of Xigris™ would be $74.8 million (44 percent of $170 million).

Comment: Numerous commenters recommended that we approve Xigris™. Many of the commenters described Xigris™ as a major advance in the treatment of patients with severe sepsis. However, some commenters indicated that its use has substantially increased the costs of caring for these patients. One commenter reported rationing of this drug at some institutions due to cost considerations. Another commenter submitted an article from a pharmaceutical newsletter recommending the ''best method for patient selection is to use the criteria for enrollment in the PROWESS trial.''

Response: We are pleased to approve Xigris™ for add-on payments under this provision. As described above, we believe this drug represents a substantial improvement over currently available therapies for the treatment of severe sepsis in patients who have a high risk of death. We note that our finding that Xigris™ represents a substantial clinical improvement is limited to the indications and contraindications listed in the approved FDA labeling guidelines.

Comment: Some commenters, including the applicant, objected to CMS' request for additional data and endpoints beyond those requested by the FDA for its approval of Xigris™. The commenters argued that the FDA has the regulatory responsibility to monitor safety and efficacy of drugs and medical devices and provides rigorous review and oversight to the approval of drugs. They further contended that the placement of drugs under FDA ''priority review'' process for approval should be given weight when determining whether a drug meets the CMS ''substantial improvement'' criteria.

According to the commenters, by asking manufacturers for additional data to determine if an applicant meets our substantial clinical improvement criteria, CMS has inappropriately substituted its judgment for that of the FDA. The commenters suggested that we implement policies to ensure that these ''improprieties'' will not be repeated. One commenter argued that, if we plan to ask for unpublished data from future sponsors, we should amend our rulemaking to specify the conditions under which unpublished data may be required.

Response: Although we are affiliated with the FDA and we do not question the FDA's regulatory responsibility for decisions to approve drugs, we are not using FDA guidelines to determine what drugs, devices, or technologies qualify for new technology add-on payments under Medicare. Our criteria do not depend on the standard of safety and efficacy that the FDA sets for general use, but on a demonstration of substantial clinical improvement in the Medicare population (particularly patients over age 65).

To clarify this distinction, we offer the following example. The FDA approves a drug for general use to control the effects of seasonal allergies. This drug works well and has minimal side effects, but it makes some people feel nauseous if they take it without food. Two years later, another company creates a new allergy medicine that does not cause nausea. This drug also gets approval from the FDA. This does not necessarily mean that the new drug represents a substantial clinical improvement over the existing drug. The new drug may be better for some patients to take, but it is only an equivalent treatment, or another option, to the first drug. Therefore, the new drug would not meet the CMS substantial clinical improvement criteria.

We also disagree with the suggestion that the FDA priority review process should be the standard by which CMS should approve new technologies for add-on pass-through payments. We do not want to accept a priority review determination by the FDA as a *de facto* substantial improvement determination by us because: (1) The FDA decision is made prior to reviewing all the clinical data about the product (the decision to review the marketing application as a priority review is made at the beginning of the review process); (2) if the FDA changes its criteria for priority review, it would change the criteria for substantial improvement; (3) the current criteria used by the FDA for priority review are not the same across product types; (4) the criteria for priority review are not exactly the same as CMS substantial improvement in all instances; and (5) it would mean that the FDA would be making a *de facto* reasonable and necessary determination, since a product that offers a substantial improvement is certainly reasonable and necessary.

With respect to the comments regarding the request for submission of unpublished data, we note that the September 7, 2001 final rule indicated that we would require applicants to submit evidence that the technology does provide a substantial clinical improvement over existing technologies (66 FR 46914). Therefore, we disagree with the commenter that it is necessary to amend our regulatory process in this regard.

Comment: The applicant commenter made several additional points in addition to the previous comment. The

applicant objected to the suggestion in the proposed rule that payment would likely be limited to patients meeting the FDA labeling guidelines. The applicant also objected to the statement in the proposed rule that the charge data submitted did not represent a random sample. The applicant reiterated its estimate that 25,000 Medicare beneficiaries would receive Xigris™ in FY 2003.

Response: We are approving Xigris™ for add-on payments on the basis that it represents a substantial clinical improvement over other treatments for patients consistent with the FDA-listed indications. We do not have an administrable mechanism to identify patients who may receive this drug without having the FDA-listed indications. We will review potential options to enable us to more precisely make such distinctions in the future. We reserve the right to reexamine the issue of limiting the types of patients for which add-on payments are made for FY 2004.

In determining whether a new technology is eligible for add-on payments, we compare the average standardized charges of cases involving the applicant technology to the weighted threshold of the relevant DRGs, which reflects the charges of all cases in those DRGs that are discharged from all hospitals (weighted by the number of cases in each DRG). Thus, our statement that the data submitted did not represent a random sample was made in the context of measuring whether the average standardized charge of the PROWESS trial data was statistically significantly higher than the threshold. In order for such a significance test to be truly valid, the trial cases would have to have been drawn randomly from all cases and all hospitals with cases in the relevant DRGs. Clearly, the PROWESS trial was not designed in this manner, nor would we expect it to be. Thus, we were attempting to approximate a standard using a methodology that requires certain assumptions that were not met by the data at hand, and we were merely acknowledging it was only an approximation.

As stated above, we believe the applicant's estimate of 25,000 Medicare patients receiving Xigris™ during FY 2003 does not reflect cases without multiple organ failures but with APACHE II scores in the third and fourth quartiles.

Comment: Some commenters noted that ICD–9–CM codes do not distinguish between dosage amounts for drugs. They recommended (at least until ICD–10–PCS becomes available) relying on ICD–9–CM for identifying new procedures such as a new pancreas implant or a minimally invasive hip replacement; and incorporating the HCPCS Level II codes. (HCPCS stands for Health Care Financing Administration [recently renamed the Centers for Medicare & Medicaid Services] Common Procedure Coding System) for new drugs or supplies.

One commenter indicated that ICD–9–CM codes appear to be sufficient at this time, but, as new technologies proliferate, they will become overwhelming. However, the commenter did request guidance from us about using ''nontraditional'' ICD–9–CM codes, as well as information about reporting these codes in instances where more than six procedure codes (the maximum spaces provided on the bill) are involved.

Response: We appreciate the insight provided by this commenter regarding future coding options and will take it into consideration as we look to future refinements to this policy. However, for the reasons addressed at length in the September 7, 2001 final rule, we are using the ICD–9–CM codes at this time to identify cases eligible for the new technology add-on (66 FR 46909–10). However, because of limited space available for new ICD–9–CM codes, we are unable at this time to differentiate the volume of drugs that are administered. Therefore, as described above, we will pay on the basis of an average dose per patient.

As stated above, add-on payments for Xigris™ will be calculated for cases identified by use of the ICD–9–CM code 00.11 (when other conditions are met). In relation to guidance on the use of this code, we believe the documentation requirements are straightforward: consistent with the definition of the code, the medical record must indicate infusion of drotrecogin alfa (activated). With respect to situations where more than six procedure codes may be involved, hospitals should follow normal coding guidelines for selecting which codes to include.

b. Bone Morphogenetic Proteins (BMPs) for Spinal Fusions

BMPs have been isolated and shown to have the capacity to induce new bone formation. Using recombinant techniques, some BMPs (referred to as rhBMPs) can be produced in large quantities. This has cleared the way for their potential use in a variety of clinical applications such as in delayed unions and nonunions of fractured bones and spinal fusions. One such product, rhBMP–2, is developed for use instead of a bone graft with spinal fusions.

An application was submitted by Medtronic Sofamor Danek for the InFUSE™ Bone Graft/LT–CAGE™ Lumbar Tapered Fusion Device for approval as a new technology eligible for add-on payments. The product is applied through use of an absorbable collagen sponge and an interbody fusion device, which is then implanted at the fusion site. The patient undergoes a spinal fusion, and the product is placed at the fusion site to promote bone growth. This is done in place of the more traditional use of autogenous iliac crest bone graft.

In 1997, in a pilot study conducted under a FDA approved device exemption, 14 patients were enrolled at 4 investigational sites. Eleven patients received rhBMP–2, with 3 control patients. Radiographs and computed tomography scans at 6, 12, and 24 months after surgery showed that all 11 patients who received rhBMP–2 had solid fusions, whereas only 2 of the 3 patients who received autogeneous bone graft had solid fusions. Scores from the Oswestry Low Back Pain Disability Questionnaire showed that 6 of 11 patients treated with rhBMP–2 had a successful outcome at 3 months after surgery, compared with 0 of 3 control patients. After 6 months, the results had changed to 7 of 11 rhBMP–2 patients and 2 control patients with successful treatments; and at 12 months, 10 rhBMP–2 patients and 2 control patients were judged successful. The results were unchanged at 24 months. The trial results were presented in an article in the February 1, 2000 edition of SPINE (Bone, S., Zdeblick, T., et al., ''The Use of rhBMP–2 in Interbody Fusion Cages—Definitive Evidence of Osteoinduction in Humans: A Preliminary Report''), Vol. 25, No. 3, p. 376.

The above study was then expanded to involve 281 patients at 16 sites, with 143 patients in the rhBMP–2 group and 138 patients in the autogenous iliac crest bone graft group. In the rhBMP–2 group, 76.9 percent of the patients showed an improvement of at least 15 points in their disability scores at 12 months postoperatively. This compared favorably to 75 percent of patients in the control group. At 6 months following surgery, 97 percent of patients in the rhBMP–2 group showed evidence of interbody fusion, as compared to 95.8 percent in the control group. At 12 months, 96.9 percent of patients in the rhBMP–2 group were fused as compared to 92.5 percent in the control group. At this time, the results of this study are unpublished.

Cost data were submitted for 88 patients participating in the follow-up study described above. This trial was a single-level, anterior lumbar interbody fusion clinical study. Of the 88 bills with cost data, the applicant calculated an average standardized charge for these single-level fusion cases of $33,757. According to the applicant, ''it is anticipated that a large number, if not the majority, of cases using BMP technology will, in practice, be multi-level fusions.'' The applicant reported the estimated hospital charges (based on general charging practices) to be $17,780 for each level. In order to account for the use of this technology in multilevel spinal fusions, the applicant assumed 47 percent of spinal fusions were multilevel (based on analysis of Medicare spinal fusion cases). Increasing the average standardized charge for the cases in the trial by $17,780, the applicant calculated a weighted average standardized charge (53 percent single-level and 47 percent multilevel) of $45,556.

Of these 88 cases, 11 were assigned to DRG 497 (Spinal Fusion Except Cervical With CC) and 77 were assigned to DRG 498 (Spinal Fusion Except Cervical Without CC). In order to qualify for new technology payments based on these DRGs, the threshold would be $37,815.

At the time of the proposed rule, this technology was not approved for general use by the FDA. Therefore, we indicated that if the FDA approved the product for general use prior to our issuance of the final rule, we would issue a determination whether this technology represents a substantial clinical improvement under the criteria outlined in the September 7, 2001 final rule.

On July 2, 2002, the FDA approved this technology. The approval was for spinal fusion procedures in skeletally mature patients with degenerative disc disease at one level from L4–S1. Therefore, based on the FDA's approval, multilevel usages of this technology would be off-label. As noted above, this technology would meet the cost threshold only if the added costs of multilevel fusions are taken into account. Because the FDA has not approved this technology for multilevel fusions, and the applicant has not submitted data to demonstrate this technology is a substantial clinical improvement for multilevel fusions (as described above, the clinical trial upon which the application was based was a single-level fusion trial), we cannot issue a substantial clinical improvement determination for multilevel fusions. Therefore, because the average charges for this new technology, when used for single-level spinal fusions, does not exceed the threshold of $37,815 noted above, we are denying this application for add-on payments during FY 2003. Because the new technology did not qualify on the basis of charges above the thresholds, we did not make a substantial improvement determination.

Comment: A few commenters were very supportive of approving Medtronic Sofamor Danek's InFUSE™ Bone Graft technology. These commenters note that this rhBMP–2 technology is a substantial clinical improvement as it obviates the need for a second surgical procedure to harvest autogenous iliac crest bone. The commenters noted that this substantial improvement focuses mostly on relief of pain in patients because many patients who undergo bone harvesting have pain at the donor site up to 10 years after the surgery.

Several other commenters, however, recommend that we not approve this application for add-on payments. These commenters stated that ''the clinical trial results solidly counter the claim of significant improvement.'' Commenters also objected to the data that the manufacturer provided, stating that in order for the threshold to be met, the manufacturer provided estimates for procedures that would involve multilevel fusions. At the time of the proposed rule, the FDA had not approved the treatment, and commenters noted that the FDA could not approve the treatment for multilevel surgeries because it had been given no clinical evidence for these procedures. The commenters pointed out that FDA's approval (which came on July 2, 2002) could (and does) only indicate approval for use of the product for single-level fusions. Therefore, the commenters strongly opposed the approval of the BMP applicant because it does not meet our financial threshold. The commenters also were concerned that, if approved for new technology payments, the technology may be used inappropriately off label and for indications that have not been approved by the FDA.

Response: We stated in the September 7, 2001 final rule that we believe the technologies approved for add-on payments should be limited to those new technologies that have been demonstrated to represent a substantial improvement in caring for Medicare beneficiaries, such that there is a clear advantage to creating a payment incentive for physicians and hospitals to utilize the new technology (66 FR 46913). Further, we stated that we believe it is in the best interest of Medicare beneficiaries to proceed very carefully with respect to the incentives created to quickly adopt new technology.

As noted above, we are denying this application for add-on payments during FY 2003 because it does not meet our cost threshold when used for single-level spinal fusions, and there is no available evidence upon which to determine whether it represents a substantial improvement for multilevel uses.

c. Zyvox™

Zyvox™ is the first antibiotic in the oxazolidinone class and is widely used by hospitals in the United States and other countries against the medically significant gram-positive bacteria, including those that are resistant to other therapies. Gram-positive bacterial infections have become increasingly prevalent in recent years, most commonly implicated in infections in the lower respiratory tract, skin and soft tissue, bone and bloodstream, and in meningitis. Significant morbidity and mortality trends are associated with such pathogens. Epinomics Research, Inc., submitted the application on behalf of Pharmacia Corporation (Pharmacia), which markets the drug.

The FDA approved Zyvox™ on April 18, 2000, for the treatment of serious infections caused by antibiotic-resistant bacteria. The applicant contends that this qualifies Zyvox™ for approval within the 2-year to 3-year period referenced at § 412.87(b)(2). Furthermore, the applicant notes that the approval of the new ICD–9–CM code 00.14 (Injection or infusion of oxazolidinone class of antibiotics) effective October 1, 2002, will permit a more precise identification of these cases. However, as noted previously, technology will no longer be considered new after the costs of the technology are reflected in the DRG weights. Because the costs of Zyvox™ are currently reflected in the DRG weights, Zyvox™ does not meet our criterion that a medical service or technology be ''new''. The FY 2001 MedPAR data used to calculate the proposed DRG weights for FY 2003 include cases where Zyvox™ was administered. The application itself noted that the use of Zyvox™ is widespread. Therefore, even though the existing code, 99.21 (Injection of antibiotic) is a general code used for the administration of various antibiotics including Zyvox™, and does not separately identify the administration of Zyvox™ as will be possible with the new code 00.14, the charges associated with these cases are reflected in the proposed FY 2003 DRG weights.

As stated above, we note that the applicant itself points out that Zyvox™

is widely used currently by hospitals. In its 4th quarter 2001 earnings report, Pharmacia reports total sales in the United States of $97 million, which is an increase of 105 percent over the previous year. This would indicate expanding access to the drug.

We would point out that, in response to a comment that technologies should qualify as ''new'' beginning with the assignment of an appropriate tracking code, we clarified in the September 7, 2001 final rule that we would not consider technologies that have been on the market for more than 2 or 3 years to be ''new'' on the basis that a more precise ICD–9–CM procedure code has been created (66 FR 46914). However, although such technologies would not qualify for add-on payments under this provision, we did indicate that we would evaluate whether the existing DRG assignments of the technology are appropriate.

For example, currently the administration of Zyvox™ does not affect the DRG to which a case is assigned. In its application for add-on payments, Epinomics provided CMS data that included clinical trials as well as data from a sample that spanned MedPAR files from FY 2000 through FY 2002. For its sample study, Epinomics obtained patient records from 70 hospitals that used Zyvox™ treatment on 832 Medicare patients. The cases were distributed across 151 DRGs. Epinomics calculated that the mean standardized charge for these 485 cases was $74,174. The case-weighted mean standardized charge for all cases in these DRGs would be $33,740 (based on the distribution of Zyvox™ cases across the 151 DRGs).

The unit price for the drug varies from approximately $30 for a 100 milliliter bag (200 milligram linezolid) to approximately $1,350 for 600 milligram tablets (unit doses of 30 tablets). Nevertheless, it appears the high average charges associated with patients receiving the drug are not directly attributable to the administration of Zyvox™. Therefore, in the May 9, 2002 proposed rule, we did not propose any changes to the DRG assignment of these cases. We indicated that to the extent these cases are more expensive due to the severity of illness of the patients being treated, the current outlier policy will offset any extraordinarily high costs incurred.

Comment: Several commenters, including the applicant, strongly objected to our denial of Zyvox™ for new technology payments. They criticized our decision not to approve it on the grounds that payments for this expensive drug are already incorporated into the DRG recalibration for FY 2003. The commenters argued that, based on the recent assignment of an ICD–9–CM code, the drug still qualifies for add-on payments under the Congressional intent of the law.

The commenters referenced the language of section 1886(d)(5)(K)(ii)(II) of the Act in support of their claim that this technology qualifies as new. They believed the 2-year to 3-year period ''beginning on the date on which an inpatient hospital code is issued with respect to the service or technology'' applicable to Zyvox™ should begin October 1, 2002, when new code 00.14 becomes effective. They argued that this new code will allow data to be accumulated to track the costs of these cases.

Response: Again, we do not believe it would be appropriate to consider technologies that have been on the market for 2 or 3 years for approval under this provision on the basis that a new, more precise, procedure code is subsequently issued. Allowing technologies that have already been in use to attain higher payments as a result of the assignment of a new, more specific ICD–9–CM code would open the door for the sponsors of any medical device or technology to consider whether they might qualify their product for add-on payments by requesting and receiving a new code from the ICD–9–CM Coordination and Maintenance Committee. We do not believe it was Congress' intent that this provision should be interpreted that way.

Therefore, it is necessary to establish a point after which previously existing technologies are not eligible to qualify for add-on payments under this new provision. We believe it is reasonable to establish the cutoff point such that those technologies with data available in the FY 2001 MedPAR to be included in the calculation of the FY 2003 DRG weights will not be eligible for new technology payments. We note that this process of incorporating new technologies into existing DRGs, where they eventually affect the weights depending on their utilization, was how all new technologies have been introduced since 1984. While we recognize Congress' intent to revise this process to expedite the introduction of new technologies, there was no indication in the legislation that the new policy was to apply to technologies whose costs were already reflected in the DRG weights.

Comment: The applicant criticized CMS for delaying the implementation of the provision. The commenter noted that the provision was to be implemented, ''[n]ot later than October 1, 2001'' and stated that CMS failed to implement the law by October 1, 2001. They argued that, by delaying the implementation, CMS effectively prevented Zyvox™ from ever meeting the ''new'' criteria, even though the drug got approval only 8 months before the provision was passed.

Response: We disagree that we delayed implementation of this provision. In the September 7, 2001 final rule, we stated that, although we did not approve any new technologies for add-on payments effective October 1, 2001, we did carefully evaluate all technologies that were brought to our attention, either as a result of our internal analysis or by the public, including those submitted for consideration during the public comment period on the May 4, 2001 proposed rule. Zyvox™ was not among the technologies submitted for consideration at that time.

Comment: Commenters argued that, although Zyvox™ was available and used during FY 2001, and therefore would be reflected in hospitals' charges used to set the FY 2003 DRG relative weights, due to the high cost of the drug, it is far from clear that hospitals prescribed the product for the majority of Medicare patients for whom it would be most appropriate. Therefore, the impact of the costs of the drug on the DRG weights is understated.

Response: We cannot assess whether the utilization of Zyvox™ was hampered by Medicare payments during FY 2001. However, we would note that Zyvox™ was treated in the same manner as other new technologies have been over the years. Further, we will continue to evaluate the appropriateness of payment for these patients as we do all other technologies and patient categories.

Comment: One commenter objected to the reference to Zyvox™ sales figures as evidence of expanding general access to the drug. The commenter stated that we provided no evidence to indicate this sale growth is the result of expanding use in the treatment of Medicare beneficiaries. The commenter went on to argue that ''sales reports and other company financial data must be considered outside the scope of the review process.''

Response: We disagree that we should ignore sales reports related to a product seeking additional payments to promote its expansion into the medical market. This market analysis was certainly not the basis for our decision not to approve this applicant, as described above. The sales reports were simply a portion of data we considered in our evaluation of the effects of our decision. We also note

that we received no evidence during the comment period to document that the sales growth referenced above did not pertain to Medicare beneficiaries.

Comment: The applicant expressed concern that, during discussions and meetings with CMS, no mention was made that there might be an issue related to the application meeting the ''new'' criterion.

Response: The criteria to qualify for add-on payments were specified clearly in the September 7, 2001 final rule. Clearly, the applicant believed it met the criteria, as evidenced by the fact that it applied and its subsequent comments on our proposed decision. The facts regarding the point at which Zyvox™ was approved by the FDA and when it became available for use are agreed upon. The difference of opinion centers on the criteria for ''new''. The commenter has described its interpretation, with which we disagree, as discussed above. The public comment process is part of the review and approval process. We believe the public comment process is the most appropriate avenue to consider the interpretation of legislative and regulatory criterion. As discussed above, we do not believe that it would be appropriate to allow technologies that have already been in use to attain higher payments as a result of the assignment of a new, more specific, ICD–9–CM code.

d. Renew™ Radio Frequency Spinal Cord Stimulation Therapy

An application was submitted by Advanced Neuromodulation Systems (ANS) for the Renew™ Spinal Cord Stimulation Therapy for approval as a new technology eligible for add-on payments. ANS is a medical device company that deals with management of chronic pain that is severe, persistent, and unresponsive to drugs or surgery. Spinal cord stimulation (SCS) offers a treatment alternative to expensive ongoing comprehensive care. Renew™ SCS was introduced in July 1999 as a device for the treatment of chronic intractable pain of the trunk and limbs.

According to the applicant:

''SCS is a reversible method of pain control that works well for certain types of chronic intractable pain. SCS requires a surgical procedure to implant a receiver and leads. These implanted devices generate electrical stimulation that interrupts pain signals to the brain. SCS is considered to be a treatment of last resort, and is usually undertaken only when first and second-line therapies for chronic pain fail to provide adequate relief. SCS uses low-intensity electrical impulses to trigger nerve fibers selectively along the spinal cord. The stimulation of these nerve fibers diminishes or blocks the intensity of the pain message being transmitted to the brain. SCS replaces areas of intense pain with a more pleasant sensation * * *,'' masking the pain that is normally present.

Prior to Renew™, SCS systems offered few technical capabilities for treating complex chronic pain patients who suffered with pain that spanned noncontiguous areas (multi-focal) or that varied in intensity over the painful area. The Renew™ system features a multiplex output mode that controls separate stimulation programs to allow outputs of varying frequencies to be used at the same time. According to ANS, ''The significance of this technology is that it is now possible to multiplex (link and cycle) up to 8 programs to provide pain relieving paresthesia overlap of anatomical regions that are not contiguous or that cannot be captured by a single program.''

The Renew™ technology also allows the concomitant use of separate programs for patients who require different power settings for different areas that have pain. With this technology, separate programs can be programmed from the same unit, with electrical output parameters customized for each painful region. ANS contends that the clinical significance of this technology is that patients who find satisfactory pain relief will require fewer alternative treatments to treat unrelieved pain.

The ANS application specifically requests add-on payments for the costs of the Radio Frequency System (RF System). This system only requires one surgical placement and does not require additional surgeries to replace batteries as do other internal SCS systems. ANS estimates that there are 2,900 RF Systems implanted annually; only 10 percent are in the inpatient setting. ANS is the only company that offers a 16-channel/electrode system.

ANS provided the 2001 hospital acquisition cost for ANS Renew™ 8 and 16 Channel/Electrode RF SCS Systems as follows:

	ANS 2001 list price
8 Channel/Electrode System:	
One Lead (8 Electrode)	$2,750.00
One Extension (8 Electrode)	695.00
Receiver (8 Channel)	4,995.00
Transmitter (8 Channel)	4,995.00
Total System	13,435.00
16 Channel/Electrode System:	
Two Leads (16 electrode)	5,550.00
Two Extensions (16 electrode)	1,390.00
Receiver (16 Channel)	7,295.00
Transmitter (16 Channel)	7,295.00
Total System	21,480.00

Currently, implanting the ANS 8 or 16 Channel/Electrode SCS System falls into DRG 4 (Spinal Procedures) under ICD–9–CM procedure code, 03.93 (Insertion or replacement, spinal neurostimulation). According to the September 7, 2001 **Federal Register**, the threshold to qualify for additional new technology payments for services classified to DRG 4 would be $38,242 (based on adding the geometric mean and the standard deviation of standardized charges) (66 FR 46922).

Relative to hospital invoice information, ANS provided the following estimates:

'' * * * 90% of the U.S. hospital cost-to-charge ratios fall between .24 and .69, and 75% fall between .29 and .58. The median is .41. This median costs-to-charge ratio equates to an average hospital markup of 144%. If you apply the average hospital markup of 144% to the device acquisition cost plus the estimated facility cost, the result is an estimated hospital invoice for the SCS implant procedure of $40,101.00, for the 8 Channel/Electrode System and $59,731.00 for the 16 Channel/Electrode System.''

In support of its application, ANS provided detailed bills for 12 patients. Of the 12 cases with detailed billing data, 3 patients were age 65 or older. The average total charge for these 3 cases, including the average standardized charge for operating room costs, was $42,820.

As noted previously, technology will no longer be considered new after the costs of the technology are reflected in the DRG weights. Because the Renew™ RF System was introduced in July 1999, the FY 2001 MedPAR data used to calculate the DRG weights for FY 2003 includes any Medicare cases that involved the implantation of the Renew™ RF System. The charges associated with these cases are reflected in the FY 2003 DRG weights. Therefore, the Renew™ RF System is not considered ''new'' under our criteria. However, we will continue to monitor these cases in DRG 4 to determine whether this is the most appropriate DRG assignment.

Comment: Several commenters objected to our proposed decision to not approve this application because the technology does not meet our criterion for ''new'' designation.

Response: We continue to believe that this technology does not meet the criterion for the reasons given in the proposed rule, as elaborated on in our response to comments discussed above in relation to Zyvox™.

III. Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by the Office of Management and Budget (OMB). OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprising two or more PMSAs (identified by their separate economic and social character). For purposes of the hospital wage index, we use the PMSAs rather than CMSAs since they allow a more precise breakdown of labor costs. If a metropolitan area is not designated as part of a PMSA, we use the applicable MSA. Rural areas are areas outside a designated MSA, PMSA, or NECMA. For purposes of the wage index, we combine all of the rural counties in a State to calculate a rural wage index for that State.

We note that, effective April 1, 1990, the term Metropolitan Area (MA) replaced the term MSA (which had been used since June 30, 1983) to describe the set of metropolitan areas consisting of MSAs, PMSAs, and CMSAs. The terminology was changed by OMB in the March 30, 1990 **Federal Register** to distinguish between the individual metropolitan areas known as MSAs and the set of all metropolitan areas (MSAs, PMSAs, and CMSAs) (55 FR 12154). For purposes of the prospective payment system, we will continue to refer to these areas as MSAs.

Under section 1886(d)(8)(B) of the Act, hospitals in certain rural counties adjacent to one or more MSAs are considered to be located in one of the adjacent MSAs if certain standards are met. Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification from a rural area to a MSA, one rural area to another rural area, or from one MSA to another MSA, for purposes of payment under the acute care hospital inpatient prospective payment system.

In a December 27, 2000 notice published in the **Federal Register** (65 FR 82228), OMB issued its revised standards for defining MSAs. In that notice, OMB indicated that it plans to announce in calendar year 2003 definitions of MSAs based on the new standards and the Census 2000 data. We will evaluate the new area designations and their possible effects on the Medicare wage index, as well as other provider payment implications. Although the final construct of the redefined MSAs will not be known until 2003, we intend to work closely with OMB to begin to assess the potential ramifications of these changes.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey should measure, to the extent feasible, the earnings and paid hours of employment by occupational category, and must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. As discussed below in section III.F. of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating the wage index.

Section 304(c) of Public Law 106–554 amended section 1886(d)(3)(E) of the Act to provide for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. The initial collection of these data must be completed by September 30, 2003, for application beginning October 1, 2004 (the FY 2005 wage index).

In the May 4, 2001 proposed rule (66 FR 22674), we suggested possible occupational categories from the Occupational Employment Statistics (OES) survey conducted by the Bureau of Labor Statistics. In response to comments on the proposed rule, we agreed to work with the health care industry to develop a workable data collection tool. After we develop a method that appropriately balances the need to collect accurate and reliable data with the need to collect data that hospitals can be reasonably expected to have available, we will issue instructions as to the type of data to be collected, in advance of actually requiring hospitals to begin providing the data.

Comment: Commenters strongly encouraged us to take the time needed to develop the most appropriate survey instrument for collecting occupational mix data and to provide adequate time for hospitals to have available the required information. One commenter wrote that neither CMS nor the hospital industry is ready to implement an occupational mix adjustment. The commenter believed that, when the law was passed requiring occupational mix data to be collected by the end of September 2003, Congress did not understand the burden and complexity of collecting and using the information. The commenter noted that, over 10 years, CMS encountered many problems when it first tried to collect occupational mix data and believed that, today, hospitals are in no better position to provide the necessary information.

A commenter also requested that we publish a rule for comment that delineates our proposed occupational mix methodology and illustrates how the index mix would be calculated and used to adjust the overall wage index. The commenter expressed interest in continuing to work with us on this effort.

MedPAC has recommended that CMS collect the occupational mix data as part of the Medicare cost report, just as the wage data are currently collected. MedPAC notes that a separate survey usually has a lower initial response rate, and incorporating the survey as part of the cost report should minimize reporting burden on hospitals, enhance data accuracy, and help to achieve a 100-percent response rate. MedPAC recommended that we modify the cost report form and instructions as soon as possible to enable the collection of this data during the second round of data collection. MedPAC also recommended that we provide detailed information as soon as possible to hospitals regarding the specific occupational mix data they will be required to report in order to allow hospitals time to modify their information systems to collect the necessary wage and hours data. Although, MedPAC acknowledges it may not be possible to collect accurate data for FY 2002, it believes that it still may be feasible to collect the data for FY 2003 and meet the Congressional mandate to implement an occupational

mix adjustment for the FY 2005 wage index.

A few commenters expressed concern that an occupational mix adjustment would only recognize geographical differences in the price hospitals pay for a particular employee category and would not reflect that a hospital, such as a teaching hospital, may have higher labor costs because its patient population requires a larger number of highly skilled, highly priced employees. The commenters noted that a previous MedPAC study showed that an occupational mix adjustment would lower the wage index values for many areas where teaching hospitals are located. The commenters also expressed concern that Medicare's current DRG payment system does not adequately recognize patient severity and the higher resource costs that are associated with treating complex patients. The commenters believed that the current wage index methodology more appropriately reflects a higher employee skill mix, as reflected in higher wage indices where teaching hospitals are located, allowing teaching hospitals to recoup some of the losses they incur under the current DRG system. The commenters suggested that, if we include an occupational mix adjustment in the wage index, we should also refine the DRG system to ensure that more complex cases are adequately reimbursed.

Response: We appreciate all the comments we received and the continued support and assistance of hospitals in developing the occupational mix adjustment. Before implementing the adjustment, we will publish the details of the occupational mix methodology in the **Federal Register** and provide for public comment.

B. FY 2003 Wage Index Update

The FY 2003 wage index values in section V. of the Addendum to this final rule (effective for hospital discharges occurring on or after October 1, 2002 and before October 1, 2003) are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1999 (the FY 2002 wage index was based on FY 1998 wage data).

The final FY 2003 wage index includes the following categories of data associated with costs paid under the hospital inpatient prospective payment system (as well as outpatient costs), which were also included in the FY 2002 wage index:

- Salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Certain contract labor costs and hours.
- Wage-related costs.

Consistent with the wage index methodology for FY 2002, the wage index for FY 2003 also continues to exclude the direct and overhead salaries and hours for services such as skilled nursing facility (SNF) services, home health services, and other subprovider components that are not paid under the hospital inpatient prospective payment system.

We calculate a separate Puerto Rico-specific wage index and apply it to the Puerto Rico standardized amount. (See 62 FR 45984 and 46041.) This wage index is based solely on Puerto Rico's data. Finally, section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State.

C. FY 2003 Wage Index

1. Removal of Wage Costs and Hours Related to Graduate Medical Education (GME) and Certified Registered Nurse Anesthetists (CRNAs)

Because the hospital wage index is used to adjust payments to hospitals under the acute care hospital inpatient prospective payment system, the wage index should, to the extent possible, reflect the wage costs associated with those cost centers and units paid under the hospital inpatient prospective payment system. Costs related to graduate medical education (GME) (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs) are paid by Medicare separately from the hospital inpatient prospective payment system. In 1998, the AHA convened a workgroup to develop a consensus recommendation on this issue. The workgroup, which consisted of representatives from national and State hospital associations, recommended that costs related to GME and CRNAs be phased out of the wage index calculation over a 5-year period. Based upon our analysis of hospitals' FY 1996 wage data, and consistent with the AHA workgroup's recommendation, we specified in the July 30, 1999 final rule (64 FR 41505) that we would phase out these costs from the calculation of the wage index over a 5-year period, beginning in FY 2000.

FY 2003 would be the fourth year of the phaseout. Therefore, the wage index calculation for FY 2003 would blend 20 percent of a wage index with GME and CRNA costs included and 80 percent of a wage index with GME and CRNA costs removed. FY 2004 would begin the calculation with 100 percent of the GME and CRNA costs removed. However, in the May 9, 2002 proposed rule, we proposed to remove 100 percent of GME and CRNA costs from the FY 2003 wage index.

We have analyzed the FY 2003 wage index both with 100 percent of GME and CRNA costs removed and with 80 percent of these costs removed used the final wage index file. We found that the majority of labor market areas, both rural and urban, would benefit by the removal of all of these costs (304 out of 373). Only one rural labor market area would be negatively impacted by this change (New Hampshire by -0.09 percent). We note that, as part of its Report to the Congress on Medicare in Rural America (June 2001), MedPAC recommended fully implementing this phaseout during FY 2002. Similar to our findings, MedPAC found the effect of completely eliminating GME and CRNA costs ''might not be negligible for some areas, but it would not be large in any case'' (page 76). Of the urban labor market areas that would be negatively affected the decreases range from .01 to 1.0 percent.

Because we believe removing GME and CRNA costs from the wage index calculation is appropriate, and the impact is generally positive and relatively small, we proposed to remove 100 percent of GME and CRNA costs beginning with FY 2003 wage index.

Comment: Several commenters stated that, although the early elimination of GME and CRNA costs from the wage index calculation is not as significant as some other payment reductions, the proposed policy represents a net reduction in payments for some hospitals compared to payments using a wage index with 80 percent of GME and CRNA costs removed. Based on CMS' analysis presented in the proposed rule, the commenters noted that excluding 100 percent of these costs from the FY 2003 wage index would negatively affect hospitals in more than 20 percent of the labor market areas. Commenters also noted that the affected areas are primarily urban, where large teaching hospitals are more likely to be located. In addition, the commenters noted that urban hospitals have to absorb increased indigent care costs.

The commenters believed that our current 5-year phaseout policy was the result of a good-faith agreement negotiated with a hospital industry workgroup. They further believed that adoption of the proposed accelerated phaseout for the FY 2003 wage index would establish an unfortunate

precedent that questions the rationale for hospital associations to enter into any future negotiations with CMS. The commenters request us to adhere to our original 5-year phaseout schedule.

One commenter supported our proposal to remove 100 percent of GME and CRNA costs from the FY 2003 wage index.

Response: We implemented changes to the FY 1995 cost report (used to calculate the FY 1999 wage index) in order to separately identify the wage data associated with GME and CRNAs. However, due to data reporting problems, we were unable to remove these costs until the FY 2000 wage index. In the meantime, the hospital industry established a workgroup that developed a compromise agreement on the removal of these data from the wage index, including a 5-year phaseout to alleviate the negative impact this change would have on some areas. The recommendations of the workgroup were presented to CMS, and most (but not all) of them were accepted (see the July 30, 1999 final rule, 64 FR 41505). However, we note that CMS was not a party to the industry workgroup that developed the compromise agreement.

As noted above, Medicare pays hospitals for GME and CRNA costs separately from the acute care hospital inpatient prospective payment system. CMS is responsible for ensuring the accuracy and fairness of the wage index and it is our assessment at this time that, due to the small impact as described above, of removing GME and CRNA costs from the wage index, and because hospitals that are negatively impacted by this change are in areas that have benefited from the inclusion of these costs over the years, it is in the interest of improving the overall fairness of the wage index to accelerate the phaseout. Therefore, we are proceeding with removing 100 percent of GME and CRNA costs beginning with the FY 2003 wage index.

Comment: One commenter representing CRNAs requested that we continue to include in the wage index the costs of contract CRNAs who are used by hospitals to address staffing shortages. The commenters noted that our proposal recognizes the fact that hospitals are increasingly reliant upon contract labor for providing direct and indirect patient care. The commenter believed that hospitals should not be penalized for having to use contract CRNAs to meet staffing needs.

Response: As explained above, we believe the wage index should, to the extent possible, reflect those costs for which hospitals receive payment under the acute care hospital inpatient prospective payment system. Because hospitals are not paid under this system for CRNAs' services, we continue to believe that CRNA costs are appropriately excluded from the wage index.

2. Contract Labor for Indirect Patient Care Services

Our policy concerning the inclusion of contract labor costs for purposes of calculating the wage index has evolved with the increasing role of contract labor in meeting special personnel needs of many hospitals. In addition, improvements in the wage data have allowed us to more accurately identify contract labor costs and hours. As a result, effective with the FY 1994 wage index, we included the costs for direct patient care contract services in the wage index calculation, and with the FY 1999 wage index, we included the costs for certain management contract services. (The August 30, 1996 final rule (61 FR 46181) provided an in-depth discussion of the issues related to the inclusion of contract labor costs in the wage index calculation.) Further, the FY 1999 wage index included the costs for contract physician Part A services, and the FY 2002 wage index included the costs for contract pharmacy and laboratory services.

We continue to consider whether to expand our contract labor definition to include more types of contract services in the wage index. In particular, we have examined whether to include the costs for acquired dietary and housekeeping services, as many hospitals now provide these services through contracts. Costs for these services tend to be below the average wages for all hospital employees. Therefore, excluding the costs and hours for these services if they are provided under contract, while including them if the services are provided directly by the hospital, creates an incentive for hospitals to contract for these services in order to increase their average hourly wage for wage index purposes.

It has also been suggested that we expand our definition to include all contract services, including both direct and indirect patient care services, in order to more appropriately calculate relative hospital wage costs. Our goal is to ensure that our wage index policy continues to be responsive to the changing need for contract labor and allow those hospitals that must depend on contract labor to supply needed services to reflect those costs in their wage data. At the same time, we are concerned about hospitals' ability to provide documentation that sufficiently details contract costs and hours. The added overhead, supplies, and miscellaneous costs typically associated with contract labor may result in higher costs for contract labor compared to salaried labor. If these costs are not separately identifiable and removed, they may cause distortions in the wage index.

We agree that it may be appropriate to include indirect patient care contract labor costs in the wage index. However, in light of concerns about hospitals' ability to accurately document and report these costs, we believe the best approach is to assess and include these costs incrementally. Through incremental changes, we can better determine the impact that specific costs have on area wage index values. Also, by including these costs incrementally, hospitals and fiscal intermediaries are able to adjust to the additional documentation and review requirements associated with reporting the additional contract costs and hours.

In the May 9, 2002 proposed rule, we proposed to begin collecting contract labor costs and hours for management services and the following overhead services: administrative and general, housekeeping, and dietary. We selected these three overhead services because they are provided at all hospitals, either directly or through contracts, and together they comprise about 60 percent of a hospital's overhead hours. In addition, consistent with our consideration of administrative and general services, we proposed to collect costs and hours associated with contract management services that are not currently included on Worksheet S–3, Part II, Line 9 (that is, management services other than those of the chief executive officer, chief financial officer, chief operating officer, and nurse administrator).

Comment: Several commenters supported our continuing efforts to examine contract labor costs for inclusion in the wage index and to ensure that the wage index is not manipulated to distort an area's wage level. MedPAC commented that ''excluding contract labor costs may affect the accuracy of the wage index and introduces undesirable incentives that may affect hospital employment decisions.'' However, some commenters cautioned that it will be challenging for hospitals to provide the required detailed data and documentation for the appropriate costs and hours and to exclude nonlabor expenses, such as equipment and supplies, from total contract expenses. The commenters believed that, for most housekeeping and dietary services contracts,

meaningful data regarding hours are nonexistent. For management contracts, some commenters believed that the collection of cost and hours data may be more feasible. However, the contract itself may not provide enough detail to be a sufficient source of documentation. One commenter disagreed with the inclusion of contract labor costs in the administrative and general cost center because the commenter believed that the types of costs reported in that center vary too widely across hospitals to be comparable.

The commenters advised that it is important for us to ensure consistency among fiscal intermediaries in their auditing of supporting documentation for contract labor. Further, some commenters supported a delay in including the additional contract labor costs until we develop clear definitions and acceptable methods for tracking the costs and hours. A delay would also allow hospitals more time to assure the appropriate and accurate collection of the required data. One commenter also requested that CMS make the new data regarding contract labor costs available for review, analysis, and comment prior to including these costs in the wage index.

Response: Due to, among other things, the general support we received for our proposal to include costs for contract indirect patient care services in the wage index, we are proceeding as proposed. We will revise the cost report form and instructions, as early as it is feasible to do so. We also will monitor the hospital industry for information regarding hospitals' ability to provide the data. Further, we will work with hospitals and intermediaries to develop acceptable methods for tracking the costs and hours. Finally, before including these additional costs in the wage index, we will provide a detailed analysis of the impact of including these additional costs in the wage index values in the **Federal Register** and provide for public comment. Our final decision on whether to include contract indirect patient care labor costs in our calculation of the wage index will depend on the outcome of our analyses and public comments.

Comment: One commenter believed that, in order to be a true measure of labor market differences, the wage index should reflect only those jobs and employment practices that are the same in every geographic area. In addressing the disparity in the current wage index policy that excludes the costs for contracted low paying jobs from the wage index, while the costs for the same services under direct hire are included, the commenter suggested that we consider excluding from the wage index all labor costs that are obtained under different methods across hospitals.

Response: The use of contract labor is widespread among hospitals, and the practice of hiring under contract exists to some degree in virtually every service a hospital provides. Under the commenter's proposal, the resulting wage index would reflect too few categories of services to be representative of hospitals' labor force. Therefore, we believe it would not be feasible to exclude from the wage index all services that are obtained by hospitals using different employment methods.

D. Verification of Wage Data From the Medicare Cost Report

The data for the FY 2003 wage index were obtained from Worksheet S–3, Parts II and III of the FY 1999 Medicare cost reports. The data file used to construct the wage index includes FY 1999 data submitted to us as of July 2002. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. The unresolved data elements that were included in the calculation of the proposed FY 2003 wage index have been resolved and are reflected in calculation of the final FY 2003 wage index.

The final rule we removed data for 36 hospitals that failed edits. For 14 of these hospitals, we were unable to obtain sufficient documentation to verify or revise the data because the hospitals are no longer participating in the Medicare program, are under new ownership, or are in bankruptcy status, and supporting documentation is no longer available. We identified 22 hospitals with incomplete or inaccurate data resulting in zero or negative, or otherwise aberrant, average hourly wages. Therefore, the hospitals were removed from the calculation. As a result, the final FY 2003 wage index is calculated based on FY 1999 wage data for 4,797 hospitals.

Comment: One commenter requested that we remove the data from the FY 2003 wage index calculation for a specific hospital that closed in 2001. According to the commenter, the hospital had a major accounting and recordkeeping problem dating back several years.

Response: We have always maintained, subject to limited expectations, that any hospital that is in operation during the data collection period used to calculate the wage index should be included in the database, since the hospital's data reflect conditions occurring in that labor market area during the period surveyed (59 FR 45353). While we also believe it is appropriate to eliminate data for terminated hospitals when there is reason to believe that the data are incorrect, and the data cannot be verified due to the hospital's closure, if the wage data for a terminated hospital does not fail any of our edits for reasonableness, the hospital's data are included in the calculation of the area's wage index.

During FY 1999, the period used to calculate the FY 2003 wage index, the hospital in question was the second largest hospital in its MSA. We find the hospital's FY 1999 Worksheet S–3 wage data to be consistent with hospitals of similar size in the MSA. Therefore, we will retain the wage data for the closed hospital in the FY 2003 wage index. We also note that removing the hospital's data from the wage index calculation would actually lower the MSA's wage index value.

Comment: One commenter representing a national hospital association requested that CMS add a fatal edit to the cost reporting systems to eliminate obvious errors that are difficult or impossible to correct 4 years later when we use the data for the wage index. Examples of such errors are negative average hourly wages or a line item that includes salaries but no associated hours. Currently, we delete the problematic data elements, but the commenter believed that this does not necessarily make the reported data better, nor does it make the data consistent with data reported by other hospitals. The commenter recommended that we include a fatal edit that will not allow the cost report to be filed by the hospital until all required wage data have been entered.

Response: We agree with the commenter that these obvious errors should be corrected by the hospital before the cost report is filed. The cost reporting system currently has an edit that prevents the reporting of negative adjusted salaries. Therefore, no line item should have a negative average hourly wage. However, due to the complexities of the cost report software, a hospital is unable to simply adjust Worksheet S–3, Part II salaries to zero, if hours are missing or inaccurate, without also triggering a necessary adjustment to the trial balance (Worksheet A), as most salary items reported on Worksheet S–3, Part II are directly transferred from Worksheet A. Because Worksheet S–3, Part II wage

data are only used for wage index purposes, we believe it is preferable for both CMS and hospitals not to have the entire cost report rejected, and risk an untimely submission of the cost report, because the hours on Worksheet S–3, Part II are problematic.

We are working on revising the intermediaries' software to improve their edits and give them more flexibility to make adjustments directly to Worksheet S–3, Part II when the adjustments are necessary for wage index purposes only. We acknowledge that this revision would not help hospitals to detect obvious errors as early as possible, that is, before they file their cost reports with their intermediaries. However, improved intermediary edits would allow the errors to be identified and corrected before the data are submitted to us to be used in developing the wage index.

E. Computation of the FY 2003 Wage Index

The method used to compute the final FY 2003 wage index follows.

Step 1—As noted above, we based the FY 2003 wage index on wage data reported on the FY 1999 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 1998 and before October 1, 1999. In addition, we included data from some hospitals that had cost reporting periods beginning before October 1998 and reported a cost reporting period covering all of FY 1999. These data were included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 1999 data. We note that, if a hospital had more than one cost reporting period beginning during FY 1999 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 1998 and before October 1, 1999), we included wage data from only one of the cost reporting periods, the longest, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the latest period in the wage index calculation.

Step 2—Salaries—Beginning with the FY 2003 wage index, the method used to compute a hospital's average hourly wage excludes all GME and CRNA costs.

In calculating a hospital's average salaries plus wage-related costs, we subtracted from Line 1 (total salaries) the GME and CRNA costs reported on lines 2, 4.01, and 6, the Part B salaries reported on Lines 3 and 5, home office salaries reported on Line 7, and excluded salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not subject to the acute care hospital inpatient prospective payment system). We also subtracted from Line 1 the salaries for which no hours were reported on Line 4. To determine total salaries plus wage-related costs, we added to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9, 9.01, 9.02, and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

We note that contract labor and home office salaries for which no corresponding hours are reported were not included. In addition, wage-related costs for nonteaching physician Part A employees (Line 18) are excluded if no corresponding salaries are reported for those employees on Line 4.

Step 3—Hours—With the exception of wage-related costs, for which there are no associated hours, we computed total hours using the same methods as described for salaries in Step 2.

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocated overhead costs to areas of the hospital excluded from the wage index calculation. First, we determined the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 6, 7, and Part III, Line 13 of Worksheet S–3). We then computed the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Next, we computed the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determined the ratio of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 6, and 7); (2) we computed overhead wage-related costs by multiplying the overhead hours ratio by wage-related costs reported on Part II, Lines 13, 14, and 18; and (3) we multiplied the computed overhead wage-related costs by the above excluded area hours ratio. Finally, we subtracted the computed overhead salaries, wage-related costs, and hours associated with excluded areas from the total salaries (plus wage-related costs) and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 1998 through April 15, 2000 for private industry hospital workers from the Bureau of Labor Statistics' *Compensation and Working Conditions.* We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/98	11/15/98	1.04550
11/14/98	12/15/98	1.04325
12/14/98	01/15/99	1.04111
01/14/99	02/15/99	1.03880
02/14/99	03/15/99	1.03632
03/14/99	04/15/99	1.03369
04/14/99	05/15/99	1.03092
05/14/99	06/15/99	1.02801
06/14/99	07/15/99	1.02509
07/14/99	08/15/99	1.02230
08/14/99	09/15/99	1.01962
09/14/99	10/15/99	1.01687
10/14/99	11/15/99	1.01385
11/14/99	12/15/99	1.01056
12/14/99	01/15/00	1.00710
01/14/00	02/15/00	1.00358
02/14/00	03/15/00	1.00000
03/14/00	04/15/00	0.99638

For example, the midpoint of a cost reporting period beginning January 1, 1999 and ending December 31, 1999 is June 30, 1999. An adjustment factor of 1.02509 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 1999 and covered a period of less than 360 days or more than 370 days, we annualized the data to reflect a 1-year

cost report. Annualization is accomplished by dividing the data by the number of days in the cost report and then multiplying the results by 365.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B) or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

Step 7—We divided the total adjusted salaries plus wage-related costs obtained under both methods in Step 6 by the sum of the corresponding total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the national average hourly wage is $23.2295.

Step 9—For each urban or rural labor market area, we calculated the hospital wage index value by dividing the area average hourly wage obtained in Step 7 by the national average hourly wage computed in Step 8.

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $11.0086 for Puerto Rico. For each labor market area in Puerto Rico, we calculated the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate prospective payment system payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2003, this change affects 180 hospitals in 39 MSAs. The MSAs affected by this provision are identified by a footnote in Table 4A in the Addendum of this final rule.

Comment: Two commenters opposed our use of 3-year-old data for developing the wage index. The commenters believed that the FY 2003 wage index does not reflect current market conditions for nurses. For example, one commenter stated that, due to the current nursing shortage, her facility's average hourly wage has increased 10 percent over the past 18 months. However, the wage index does not adequately reflect the increased wage costs. The commenter noted that rural hospitals have been severely impacted by the nursing shortage. Since rural hospitals are reliant upon Medicare reimbursement, the commenter suggested that we revise the wage index methodology to allow the wage index to reflect labor cost increases sooner.

Response: The wage index is a relative measure, which compares area average hourly wages to the national average hourly wage. The nursing shortage and increased nursing wages are a national phenomenon. We believe the wage index is minimally impacted by inflationary effects of increased nursing costs. Increases in hospital wages overall would be reflected in the market basket.

In computing the wage index, we use data from cost reports beginning during the most recent Federal fiscal year for which we have a complete year's worth of data. For the FY 2003 wage index, that is cost reports that began during FY 1999. Because hospitals' cost reports may end as late as August or even September of the following year, it would not be feasible for us to use cost reports that began during FY 2000 (many of which would not close until the latter part of 2001). Due to the time period allowed for: (1) Hospitals to complete and submit their cost reports to their intermediaries; (2) intermediaries to perform a separate, detailed review of all hospitals' wage data and submit the results to CMS; and (3) CMS to compile a complete set of all hospitals' wage data from a given Federal fiscal year, it would not be possible to use FY 2000 cost report data to calculate the FY 2003 wage index. As described in the proposed rule (67 FR 31434) and section III.E. of this final rule, we adjust the wage index to a common period that reflects the latest cost reporting period for the filing year. For the FY 2003 wage index, this period is September 1, 1999 to August 31, 2000.

Comment: One commenter recommended that, to reflect the labor markets in which rural hospitals compete more accurately, the wage index value for a rural area should be the average of the three lowest MSA rates in the geographic area.

Response: We note that the statute requires that we apply wage indexes that reflect ''the relative hospital wage level in the geographic area of the hospital'' (section 1886(d)(3)(E) of the Act). Furthermore, in some States, there are some MSAs for which the calculated wage index value is actually lower than the rural area of the state. As we discussed in the proposed rule (67 FR 31435) and in section III.E. of this final rule, for those urban areas, we assign the statewide rural wage index value. We are uncertain as to whether the commenter considered this policy in its recommendation. While the commenter did not provide details of its rationale for the recommended change, we appreciate the commenter's suggestion and welcome a more detailed discussion and analysis.

Comment: One commenter wrote that CMS' instructions for developing wage-related costs using Generally Accepted Accounting Principles (GAAP) are inconsistently communicated by CMS staff and inconsistently applied by the fiscal intermediaries. The commenter urged us to ensure the credibility of the wage index by requiring that our staff and contractors understand and consistently apply our wage index policies to eliminate variations in interpretation and application of the wage data.

Response: In an effort to clarify our instructions and to promote consistency in hospitals' reporting and CMS' and the intermediary's handling of wage-related costs that are developed using GAAP, we have revised the cost report instructions (in Transmittals 8 and, soon to be released, 9) and the intermediary's desk review program. Because of the wide variation in GAAP methodologies, we continue to emphasize that it is the responsibility of the hospitals to be able to provide adequate support for the GAAP methodologies they apply. In addition, if a hospital believes that an intermediary may be incorrectly handling a particular issue, the hospital is encouraged to bring it to our attention. We will continue our efforts to ensure uniform reporting of the wage data.

Comment: One commenter, representing the District of Columbia,

indicated that the Washington, DC–MD–VA–WV MSA includes 16 Virginia hospitals, 13 Maryland hospitals, 12 District of Columbia hospitals, and 2 West Virginia hospitals. The commenter was concerned about the negative impact of the West Virginia and Maryland hospitals on the Washington, DC–MD–VA–WV MSA wage index (although the commenter did not specify a particular issue with the West Virginia hospitals). Unlike hospitals in all other States and the District of Columbia, Maryland hospitals, which are under a waiver from the acute inpatient prospective payment system, do not rely on the wage index adjustment factor to adjust their inpatient Medicare payments. Therefore, the commenter wrote, Maryland hospitals have no incentive to accurately report their wage costs on the Medicare cost report or to review and request corrections to CMS' wage index public use files. The commenter requested us to carefully review the impact of Maryland's all-payor system on hospitals within the same MSA.

Response: As the commenter notes, Maryland hospitals are paid under a program waiver (section 1814(b)(3) of the Act), in which the State establishes hospital inpatient and outpatient payment rates for Medicare, Medicaid, and private payors. The Medicare wage index is not a factor in the State's ratesetting methodology. However, in recent years the wage index has been applied to the Medicare payment rates for other providers that are not under the State's waiver, such as SNFs, hospices, and home health agencies. Many Maryland hospitals own, or are members of systems that own, facilities or entities that are now directly impacted by the quality of the hospitals' reported data.

As with all hospitals in the wage index, we edited the FY 1999 wage data for the Maryland and West Virginia hospitals. We found no significant problems in their wage data. We believe that the Maryland hospitals' wage data are reasonable for the State and the MSA. The lower average hourly wages for the West Virginia hospitals are comparable to other hospitals in that State. Furthermore, under OMB's definition of the Washington, DC–MD–VA–WV MSA, these Maryland and West Virginia hospitals are part of that MSA. Therefore, the wage data for these hospitals will continued to be used in the calculation of the area wage index for the Washington DC–MD–VA–WV MSA.

F. Revisions to the Wage Index Based on Hospital Redesignation

1. General

Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system. Hospitals can elect to reclassify for the wage index or the standardized amount, or both, and as individual hospitals or as rural groups. Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. Hospitals must apply for reclassification to the MGCRB, which issues its decisions by the end of February for reclassification to become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are in §§ 412.230 through 412.280.

Section 1886(d)(10)(D)(v) of the Act provides that, beginning with FY 2001, a MGCRB decision on a hospital reclassification for purposes of the wage index is effective for 3 fiscal years, unless the hospital elects to terminate the reclassification. Section 1886(d)(10)(D)(vi) of the Act provides that the MGCRB must use the 3 most recent years' average hourly wage data in evaluating a hospital's reclassification application for FY 2003 and any succeeding fiscal year.

Section 304(b) of Public Law 106–554 provides that, by October 1, 2001, the Secretary must establish a mechanism under which a statewide entity may apply to have all of the geographic areas in the State treated as a single geographic area for purposes of computing and applying a single wage index, for reclassifications beginning in FY 2003.

Beginning October 1, 1988, section 1886(d)(8)(B) of the Act permits a hospital located in a rural county adjacent to one or more urban areas to be designated as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards published in the **Federal Register** on January 3, 1980 (45 FR 956) for designating MSAs (and for designating NECMAs), and if the commuting rates used in determining outlying counties (or, for New England, similar recognized area) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs (or NECMAs). Hospitals that met the criteria using the January 3, 1980 version of these OMB standards were deemed urban for purposes of the standardized amounts and for purposes of assigning the wage index.

Section 402 of Public Law 106–113 provided that, for FYs 2001 and 2002, hospitals could elect whether to apply standards developed by OMB in 1980 or 1990 in order to qualify for redesignation under section 1886(d)(8)(B) of the Act. In accordance with section 1886(d)(8)(B)(ii)(II) of the Act, in the May 9, 2002 proposed rule, we proposed that, beginning with FY 2003, redesignation under section 1886(d)(8)(B) of the Act will be based on the standards published in the **Federal Register** by the Director of OMB based on the most recent decennial census.

2. Effects of Reclassification

The methodology for determining the wage index values for redesignated hospitals is applied jointly to the hospitals located in those rural counties that were deemed urban under section 1886(d)(8)(B) of the Act and those hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. Therefore, as provided in section 1886(d)(8)(C) of the Act, the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the area wage index determined inclusive of the wage data for the redesignated hospitals (the combined wage index value) applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals increases the wage index value for the area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value.

• The wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.

• Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred.

• Rural areas whose wage index values increase as a result of excluding the wage data for the hospitals that have been redesignated to another area have their wage index values calculated exclusive of the wage data of the redesignated hospitals.

• The wage data for a reclassified urban hospital is included in both the wage index calculation of the area to which the hospital is reclassified (subject to the rules described above) and the wage index calculation of the urban area where the hospital is physically located.

The wage index values for FY 2003 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this final rule. Hospitals that are redesignated should use the wage index values shown in Table 4C. Areas in Table 4C may have more than one wage index value because the wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.

Tables 3A and 3B in the Addendum of this final rule list the 3-year average hourly wage for each labor market area before the redesignation of hospitals, based on FYs 1997, 1998, and 1999 wage data. Table 3A lists these data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in the Addendum to this final rule includes the adjusted average hourly wage for each hospital from the FY 1997 and FY 1998 cost reporting periods, as well as the FY 1999 period used to calculate the FY 2003 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period.

We indicated in the proposed rule that, at the time the proposed wage index was constructed, that the MGCRB had completed its review of FY 2003 reclassification requests. Table 9 of this final rule shows hospitals that have been reclassified under either section 1886(d)(8)(B) or section 1886(d)(10)(D) of the Act. This table includes hospitals reclassified for FY 2003 by the MGCRB, as well as hospitals that were reclassified for the wage index in either FY 2001 or FY 2002 and are, therefore, in either the third or second year of their 3-year reclassification. This table also includes hospitals reclassified for purposes of the standardized amount and hospitals located in urban areas that have been designated rural in accordance with section 1886(d)(8)(E) of the Act. There are 54 hospitals reclassified for the wage index beginning during FY 2003. In addition, 367 hospitals are reclassified for FY 2003 based on their 3-year reclassification that became effective during FY 2001, and 181 hospitals are reclassified for FY 2003 based on their 3-year reclassification that became effective during FY 2002. There are 24 hospitals included in the 3-year reclassification from FY 2001 that were reclassified in accordance with section 152(b) of Public Law 106–113. In addition, there are 34 rural hospitals redesignated to an urban area under section 1886(d)(8)(B) of the Act, and 14 urban hospitals that have been designated rural in accordance with section 1886(d)(8)(E) of the Act. Finally, there are 59 hospitals reclassified by the MGCRB for the standardized amount for FY 2003 (including one hospital that is also redesignated under section 1886(d)(8)(B) of the Act to a different MSA). The final FY 2003 wage index values incorporate all of these hospitals. Since publication of the May 9 proposed rule, the number of reclassifications has changed because some MGCRB decisions were still under review by the Administrator and because some hospitals decided to withdraw their requests for reclassification.

Applications for FY 2004 reclassifications are due to the MGCRB by September 3, 2002. We note this is also the deadline for canceling a previous wage index reclassification withdrawal or termination under § 412.273(d) (as added by this final rule). At the time of publication the May 9, 2002 proposed rule, the internet site for reclassification (*http://www.hcfa.gov/regs/mgcinfo.htm*) was not operational. To obtain an application for MGCRB reclassification, call the MGCRB at (410) 786–1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

Changes to the wage index that resulted from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process have been incorporated into the wage index values published in this final rule. The changes may affect not only the wage index value for specific geographic areas, but also the wage index value redesignated hospitals receive; that is, whether they receive the wage index value for the area to which they are redesignated, or a wage index value that includes the data for both the hospitals already in the area and the redesignated hospitals. Further, the wage index value for the area from which the hospitals are redesignated may be affected.

In the May 9, 2002 proposed rule, we proposed limited changes and clarifications to the policies related to withdrawals, terminations, and cancellations of the 3-year wage index reclassifications. These are discussed in section V. of this preamble, including any comments received and our responses to those comments.

We receive several comments pertaining to the FY 2003 or FY 2004 MGCRB reclassification process. These are addressed below.

Comment: One commenter expressed concern that the methodology used for wage index reclassification for FY 2003 reclassification applications does not include a process by which corrections to 1996 and 1997 cost reporting data may be submitted. The commenter suggested that we allow for the correction of inaccurate data from prior years as part of a hospital's bid for geographic reclassification, and that not to allow corrections to the data results in inequities in the calculation in the average hourly wage for purposes of reclassification.

Response: Effective with reclassifications for FY 2003, section 1886(d)(10)(D)(vi)(II) of the Act provides that the MGCRB must use the average of the 3 most recent years of hourly wage data for the hospital when evaluating a hospital's request for reclassification. To evaluate applications for wage index reclassifications for FY 2003, the MGCRB used the 3-year average hourly wages published in Table 2 of the August 1, 2001 **Federal Register**. These average hourly wages are taken from data used to calculate the wage indexes for FY 2000, FY 2001, and FY 2002, based on cost reporting periods beginning during FY 1996, FY 1997, and FY 1998, respectively.

In the August 1, 2001 **Federal Register**, we revised the Medicare regulations at § 412.230(e)(2)(ii)(A) to specify that hospitals seeking reclassification must provide a 3-year average hourly wage using data from the hospital wage survey used to construct the wage index in effect for prospective payment purposes (66 FR 39934).

Hospitals have ample opportunity to verify the accuracy of the wage data used to calculate their wage index and to request revisions, but must do so within the prescribed timelines. We consistently instruct hospitals that they are responsible for reviewing their data and availing themselves to the opportunity to correct their wage data within the prescribed timeframes. Once the data are finalized and the wage indexes published in the final rule, they may not be revised, except through the mid-year correction process set forth in the regulations at § 412.63(x)(2). Accordingly, it has been our consistent policy that if a hospital does not request corrections within the prescribed timeframes for the development of the wage index, the hospital may not later seek to revise its data in an attempt to qualify for MGCRB reclassification.

Allowing hospitals the opportunity to revise their data beyond the timelines required to finalize the data used to calculate the wage index each year would lessen the importance of complying with those deadlines. The likely result would be that the data used to compute the wage index would not be as carefully scrutinized because hospitals would know they may change it later, leading to inaccuracy in the data and less stability in the wage indexes from year to year.

Comment: Several commenters requested that we clarify whether we intend to utilize OMB's new MSA standards and, if so, how we intend to incorporate the changes into the Medicare program. Relatedly, one commenter requested that we specify in the text of the final rule whether or not a hospital that was treated as a rural referral center (RRC) as of October 1, 2000, will continue to qualify for the RRC exception if their physical location becomes urban as a result of subsequent updates to metropolitan areas issued by the OMB. The commenter is concerned that the absence of a clear statement in the regulations text indicating that the grandfathered status of RRCs will continue into subsequent years could possibly result in a loss of their special status. The commenter referenced the instance when many RRCs located in areas that were redesignated as urban by OMB lost their RRC status. (See the August 29, 1997 final rule (62 FR 45999) for a more detailed explanation.)

Response: At this time, it is our understanding that OMB is not expected to announce changes to the new MSA standards until after we have published the proposed rule for FY 2004. Even if the new standards are announced in advance of the publication of our FY 2004 proposed rule, we would need time to assess their implications for payment purposes (for example, how will the new Micropolitan Areas designated by OMB, which will encompass counties currently considered rural, interact with other statutory and regulatory requirements for special hospital designation, such as an RRC).

Therefore, we intend at this time to continue to use the current MSA standards for FY 2004 acute inpatient prospective payment system payments. Hospitals applying for MGCRB reclassification for FY 2004 must apply based on the existing MSA definitions. With respect to the commenter's concern regarding the implications of the revised MSA definitions on RRCs, we are not prepared at this time to address this issue. We intend to evaluate this and other issues related to the new MSA definitions when they become available next year.

Comment: One commenter requested clarification as to whether Table 9, Hospital Reclassifications and Redesignations by Individual Hospital, is an official list and whether the wage index calculation is affected by errors in omission. The commenter indicated that the list in the proposed rule includes hospitals that have withdrawn their FY 2002 reclassifications and subsequently cancelled the withdrawal for FY 2003 and FY 2004, as well as omits hospitals that have received approval letters from the MGCRB reinstating the remaining years of the 3-year appeal.

Response: We indicated in the proposed rule that, while Table 9 shows hospitals that have been reclassified under either section 1886(d)(8)(B) or section 1886(d)(10)(D) of the Act, it may not reflect all withdrawals from reclassifications approved by the MGCRB or decisions of the CMS Administrator if those withdrawals were made subsequent to the preparation of the proposed rule. Similar to the other provisions and tables included in the proposed rule, publication of Table 9 in the proposed rule provided an opportunity for affected hospitals to review and verify the accuracy of the data. In situations such as those described by the commenter, we encourage affected providers to furnish us with specific feedback regarding the information contained in the proposed rule. Any changes that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process are incorporated into the wage index values and Table 9 published in the final rule.

Comment: Several commenters requested that the wage data for urban hospitals redesignated as rural under section 1886(d)(8)(E) of the Act, be included both in the MSA where the hospital is physically located and the rural area to which they are redesignated for purposes of the wage index. Commenters cited section 1886(d)(8) of the Act and section 152(b) of the Balanced Budget Refinement Act of 1999 (Pub. L. 106–113) in support of their request. The commenters asserted that section 1886(d)(8) of the Act protects nonreclassified hospitals from being negatively impacted by reclassifications. They also pointed out that in implementing the statutory reclassifications required by section 152(b) of Public Law 106–113, CMS calculated the wage index values of the MSAs that contain the counties specified in section 152(b) by ''including the wages of hospitals that were reclassified out of the MSA by section 152(b).'' The commenters stated that the exclusion of hospitals redesignated under section 1886(d)(8)(E) of the Act in calculating the wage index is contrary to the expectations of the hospitals prior to the enactment of this provision (by section 401 of Public Law 106–113).

Response: Section 1886(d)(8)(E) of the Act permits an urban hospital to apply to the Secretary to be treated as being located in the rural area of the State in which the hospital is located. A hospital granted redesignation under section 1886(d)(8)(E) of the Act is therefore treated as a rural hospital for all purposes of payment under the Medicare acute inpatient prospective payment system, including standardized amount, wage index, and disproportionate share calculations, as of the effective date of the redesignation. Therefore, for purposes of calculating the wage index as a result of the redesignation to a rural area, the wage index data of the redesignated hospital is treated as though the hospital were located in the rural area of the State. That is, its data are excluded from the wage index calculation for the urban area where the hospital is geographically located and included in the wage index calculation for the rural area to which the hospital is designated. This is consistent with the statutory language requiring that a hospital be treated as though it is located in a rural area.

In the case of section 1886(d)(8) of the Act, Congress specifically acted to provide special protection for rural hospitals negatively impacted by reclassifications. Section 1886(d)(8)(C) of the Act provides that rural areas are held harmless for decisions resulting from the application of section

1886(d)(8)(B) of the Act, or of decisions of the MGCRB or the Secretary. Redesignations under section 1886(d)(8)(E) of the Act are not covered under this provision.

In the case of section 152(b) of Public Law 106–113, Congress specifically directed the Secretary to treat these statutorily mandated reclassifications as decisions by the MGCRB. Section 1886(d)(8)(E) of the Act directs the Secretary to treat the redesignated hospitals as being located in the rural area of the State in which the hospital is located. We did not exclude the wages of the hospitals reclassified under section 152(b) in calculating the FY 2001 wage index for the affected areas because we believed that this approach appropriately reflected the expectations of the hospitals that had applied to reclassify into the areas affected by this provision prior to enactment of this provision. Because section 1886(d)(8)(E) of the Act has been in place for well over a year, hospitals applying for reclassification for FY 2003 could not reasonably have expected, in light of the language of that section, that they would benefit from the inclusion of the wage data of the redesignated hospitals in two different areas.

We note that the commenters' suggestion would not uniformly benefit hospitals remaining in or reclassified into the urban area from which the now rural hospital was reclassified. Our analysis indicates several such areas would be negatively impacted. The greatest positive impact would occur in the area of concern to the commenter.

3. OMB Standards for Hospitals to Qualify for Redesignation

In the August 1, 2001 final rule, we implemented section 402 of Public Law 106–113. Section 402 provided that hospitals could elect whether to apply standards developed by OMB in 1980 or 1990 in order to qualify for redesignation under section 1886(d)(8)(B) of the Act. However, section 402 also states that, beginning with FY 2003, hospitals will be required to use the standards published in the **Federal Register** by the Director of OMB based on the most recent decennial census.

At this time, the 1990 standards are the most recent available. Although OMB is working to develop updated standards based on the 2000 census, that work is not yet completed. For purposes of redesignation for FY 2003 under section 1886(d)(8)(B) of the Act, qualifying hospitals must be located in counties meeting the 1990 standards.

In the August 1, 2001 final rule, we determined that three counties that qualified for redesignation under the 1980 standards qualified for redesignation to a different MSA using the 1990 standards (66 FR 39869). These counties, which will be redesignated to the MSA to which they qualify based on the 1990 standards, are as follows:

Rural county	1980 MSA designation	1990 MSA designation
Ionia, MI	Lansing-East Lansing, MI	Grand Rapids-Muskegon-Holland, MI.
Caswell, NC	Danville, VA	Greensboro-Winston Salem-High Point, NC.
Harnett, NC	Fayetteville, NC	Raleigh-Durham-Chapel Hill, NC.

Section 402 of Public Law 106–113 amended section 1886(d)(8)(B) of the Act by adding clause (ii). This clause allowed hospitals to elect to use either the January 3, 1980 standards or March 30, 1990 standards for payments during FY 2001 and FY 2002. Several hospitals in counties that did not qualify for redesignation under the January 3, 1980 standards elected to use those older standards so they would not receive the urban designation accorded to them under section 402 because they would lose their special rural designation (that is, an RRC, a sole community hospital (SCH), or a Medicare-dependent hospital (MDH)). Under section 1886(d)(8)(B)(ii) of the Act, the option to make such an election was available only for FY 2001 and FY 2002. Effective for FY 2003, as we proposed, we are providing that hospitals located in counties qualifying for redesignation under section 1886(d)(8)(B) of the Act based on the 1990 standards will be redesignated under this provision.

We also noted in the August 1, 2001 final rule that five rural counties no longer meet the qualifying criteria when we apply the 1990 OMB standards (66 FR 39870). These rural counties are as follows: Indian River, FL; Mason, IL; Owen, IN; Morrow, OH; and Lincoln, WV. Therefore, beginning FY 2003, hospitals in these counties will not be eligible for redesignation under section 1886(d)(8)(B) of the Act unless the counties again qualify when the standards based on the 2000 census data are available.

Comment: One commenter expressed concern that the reclassification based on 1990 standards disadvantages hospitals classified as RRCs, SCHs, or MDHs by taking away their special status classification because they are no longer considered rural. The commenter was concerned that the provision is not in keeping with Congressional intent. As an alternative, the commenter suggested that an affected hospital should be allowed to request reclassification as a rural hospital under § 412.103(a)(3), which allows hospitals to be treated as rural if they qualify as either a rural referral center or a SCH.

Response: Because the law does not provide for an election on the part of the hospital for FY 2003, while specifying such an election for FYs 2001 and 2002, hospitals in affected counties are reclassified as urban. Therefore, consistent with our longstanding policy that hospitals reclassified as urban for purposes of the standardized amount are considered urban and lose their eligibility for special rural hospital status, the commenter is correct that a hospital becoming urban under section 1886(d)(8)(B)(ii)(II) of the Act would lose its special status as a result. With respect to the commenter's request that, in the event an affected hospital is not permitted the option to decline reclassification to an urban area that it may apply to be redesignated rural under § 412.103, we agree with the commenter that a reclassified hospital may seek rural redesignation under § 412.103. We will then determine whether the hospital meets the criteria for reclassification under this regulation. However, any such reclassification would be subject to the limitations on reclassification at § 412.230(a)(5)(iv), which prohibit a hospital that has been granted redesignation as a rural hospital under § 412.103 from receiving an additional reclassification by the MGCRB.

We also note that it has been brought to our attention that the reclassifications applicable under section 1886(d)(8)(B)(ii) of the Act are applicable for cost reporting periods beginning in the relevant Federal fiscal year. Therefore, in applying such reclassifications for FY 2003, they are effective as of the beginning of the hospital's cost reporting period beginning during FY 2003. This effective date has no impact on hospitals that are reclassified to the same MSA under this provision as they were reclassified into for FY 2002. Such

hospitals will be paid in accordance with the FY 2003 wage index value of the area to which they are reclassified effective with discharges on or after October 1, 2002. However, hospitals whose reclassification changes as a result of applying the 1990 standards for FY 2003 will be paid in accordance with the wage index applicable to the area to which they would otherwise have been classified were it not for section 1886(d)(8)(B)(ii) of the Act at the start of FY 2003. Then, for discharges occurring on or after the date of the start of their cost reporting period beginning during FY 2003, they will be paid in accordance with the wage index applicable to the area they are reclassified into under section 1886(d)(8)(B)(ii).

G. Requests for Wage Data Corrections

In the May 9, 2002 proposed rule, we stated that, to allow hospitals time to construct the proposed FY 2003 hospital wage index, in May 2002 we would make available a final public data file containing the FY 1999 hospital wage data.

The final wage data file was released on May 10, 2002. As noted above in section III.D. of this preamble, this file included hospitals' cost report data obtained from Worksheet S–3, Parts II and III of their FHY 1999 Medicare cost reports. In addition, Table 2 in the Addendum to this final rule contains each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 1999 data used to construct the final FY 2003 wage index.

In a memorandum dated December 19, 2001, we instructed all Medicare intermediaries to inform the prospective payment hospitals they service of the availability of the wage data file and the process and timeframe for requesting revisions. The wage data file was made available on January 12, 2002, through the Internet at CMS's home page (http://www.hcfa.gov). We also instructed the intermediaries to advise hospitals of the availability of these data either through their representative hospital organizations or directly from CMS. Additional details on ordering this data file were discussed in section IX.A. of the preamble of the May 9, 2002 proposed rule, ''Requests for Data from the Public.''

In addition, Table 2 in the Addendum to the proposed rule contained each hospital's adjusted average hourly wage used to construct the proposed wage index values for the past 3 years, including the FY 1999 data used to construct the proposed FY 2003 wage index. We noted that the hospital average hourly wages shown in Table 2 only reflected changes made to a hospital's data and transmitted to CMS prior to February 15, 2002. Changes approved by a hospital's fiscal intermediary and forwarded to CMS by April 5, 2002, were reflected in the final public use wage data file made available on May 10, 2002.

We believe hospitals had sufficient time to ensure the accuracy of their FY 1999 wage data. Moreover, the ultimate responsibility for accurately completing the cost report rests with the hospital, which must attest to the accuracy of the data at the time the cost report is filed. Hospitals should know what wage data were submitted on their cost reports. In addition, they were notified of any changes to their data as a result of their fiscal intermediary's review. However, if a hospital believed that its FY 1999 wage data were incorrectly reported, the hospital was provided an opportunity to submit corrections along with complete, detailed supporting documentation to its intermediary by February 8, 2002.

After reviewing requested changes submitted by hospitals, fiscal intermediaries transmitted any revised cost reports to CMS and forwarded a copy of the revised Worksheet S–3, Parts II and III to the hospitals. In addition, fiscal intermediaries notified hospitals of the changes or the reasons that changes were not accepted. This procedure ensures that hospitals have every opportunity to verify the data that will be used to construct their wage index values. We believe that fiscal intermediaries are generally in the best position to make evaluations regarding the appropriateness of a particular cost and whether it should be included in the wage index data. However, if a hospital disagrees with the fiscal intermediary's resolution of a policy issue (whether a general category of cost is allowable in the wage data), the hospital may contact CMS in an effort to resolve policy disputes. We noted that the April 5, 2002 deadline also applied to these requested changes. During this review, we did not consider issues such as the adequacy of a hospital's supporting documentation, as these types of issues should have been resolved earlier in the process.

These deadlines were necessary to allow sufficient time to review and process the data so that the final wage index calculation could be completed for development of the final FY 2003 prospective payment rates published in this final rule.

We have created the process described above to resolve all substantive wage data correction disputes before we finalize the wage data for the FY 2003 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above were not afforded a later opportunity to submit wage data corrections or to dispute the intermediary's decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above are not permitted to challenge later, before the Provider Reimbursement Review Board, CMS's failure to make a requested data revision (See *W. A. Foote Memorial Hospital* v. *Shalala,* No. 99–CV–75202–DT (E.D. Mich. 2001)).

As stated above, the final wage data public use file was released on May 10, 2002. Hospitals had an opportunity to examine both Table 2 of the proposed rule and the May 2002 final public use wage data file (which reflected revisions to the data used to calculate the values in Table 2) to verify the data CMS used to calculate the wage index.

As with the file made available in January 2002, CMS made the final wage data file released in May 2002 available to hospital associations and the public on the Internet. However, the May 2002 public use file was made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary in the entry of the final wage data that result from the correction process described above (with the February 8 deadline). Hospitals were encouraged to review their hospital wage data promptly after the release of the May 2002 file. Data presented at that time could not be used by hospitals to initiate new wage data correction requests.

If, after reviewing the May 2002 final file, a hospital believed that its wage data were incorrect due to a fiscal intermediary or CMS error in the entry or tabulation of the final wage data, it was provided an opportunity to send a letter to both its fiscal intermediary and CMS, outlining why the hospital believed an error existed and providing all supporting information, including relevant dates (for example, when it first became aware of the error). These requests had to be *received* by CMS and the fiscal intermediaries no later than June 7, 2002.

Changes to the hospital wage data were only made in those very limited situations involving an error by the intermediary or CMS that the hospital could not have known about before its review of the final wage data file. Specifically, at this stage of the process, neither the intermediary nor CMS accepted the following types of requests:

- Requests for wage data corrections that were submitted too late to be

included in the data transmitted to CMS by fiscal intermediaries on or before April 5, 2002.

- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the January 2002 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or CMS during the wage data correction process.

Verified corrections to the wage index received timely (that is, by June 7, 2002) are incorporated into the final wage index in this final rule, to be effective October 1, 2002.

Again, we believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage data to the fiscal intermediaries' attention. Moreover, because hospitals had access to the final wage data by early May 2002, they have had the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or CMS before the development and publication of the FY 2003 wage index in this final rule, and the implementation of the FY 2003 wage index on October 1, 2002. If hospitals availed themselves of this opportunity, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified after publication in the final rule, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(x)(2) of our existing regulations, we make midyear corrections to the wage index only in those limited circumstances in which a hospital can show (1) that the intermediary or CMS made an error in tabulating its data; and (2) that the hospital could not have known about the error, or did not have an opportunity to correct the error, before the beginning of FY 2003 (that is, by the June 7, 2002 deadline). As indicated earlier, since a hospital had the opportunity to verify its data, and the fiscal intermediary notified the hospital of any changes, we do not expect that midyear corrections would be necessary. However, if the correction of a data error changes the wage index value for an area, the revised wage index value will be effective prospectively from the date the correction is approved.

This policy for applying prospective corrections to the wage index was originally set forth in the preamble to the January 3, 1984 final rule (49 FR 258) implementing the hospital inpatient prospective payment system. It has been our longstanding policy to make midyear corrections to the hospital wage data and adjust the wage index for the affected areas on a prospective basis.

Section 412.63(x)(3) states that revisions to the wage index resulting from midyear corrections to the wage index values are incorporated in the wage index values for other areas at the beginning of the next Federal fiscal year. Prior to October 1, 1993, the wage index was based on a wage data survey submitted by all hospitals (prior to that, the data came from the Bureau of Labor Statistics' hospital wage and employment data file). Beginning October 1, 1993, as required by section 1886(d)(3)(E) of the Act, we began updating the wage index data on an annual basis. Because the wage index has been updated annually since FY 1994, § 412.63(x)(3) is no longer necessary, and in the May 9, 2002 proposed rule we proposed to delete it. Similarly, § 412.63(x)(4) provides that the effect on program payments of midyear corrections to the wage index values is taken into account in establishing the standardized amounts for the following year. Again, the wage data are now updated annually. Therefore, § 412.63(x)(4) is no longer necessary, and in the May 9, 2002 proposed rule we proposed to delete it as well.

Finally, we proposed to revise § 412.63(x)(2) to clarify that CMS will make a midyear correction to the wage index for an area only if a hospital can show that the intermediary or CMS made an error in tabulating the hospital's own data. That is, this provision is not available to a hospital seeking to revise another hospital's data that may be affecting the requesting hospital's wage index. As described above, the requesting hospital must show that it could not have known about the error, or that it did not have the opportunity to correct the error, before the beginning of the Federal fiscal year.

Comment: One commenter disagreed with the proposed revision to clarify § 412.63(x)(2). The commenter stated that the clarification that CMS will make a midyear correction to the wage index for an area only if a hospital can show that the intermediary or CMS made an error in tabulating the hospital's own data is illogical. The commenter believed that we should allow all potentially affected hospitals to report what they believe to be errors that they failed to correct before the beginning of the Federal fiscal year.

Response: We frequently instruct hospitals that they are responsible for reviewing their data and notifying the intermediary if there is an error or omission.

The proposed revision is consistent with the current rules in that it reinforces for hospitals the responsibility they have for assuring the accuracy of the wage data they submit.

The wage index is recalculated each year based on wage data from acute care hospitals nationwide. Since this calculation must be carried out on a nationwide basis, it is critical that we have the necessary data from all hospitals in a timely fashion so that the wage index values can be calculated prior to the beginning of the upcoming fiscal year. Accordingly, we set out well in advance a detailed timetable for reviewing and revising the data that hospitals, fiscal intermediaries, and CMS must follow. In this way, all hospitals are given an equal opportunity to review and correct their data within the established process. To further assist in the wage data review process, we require that fiscal intermediaries notify state hospital associations when a hospital fails to respond to issues raised during the wage data review process. The purpose of the notification is to inform the hospital association that its member hospital's failure to respond to matters raised by the fiscal intermediary can result in data being disallowed, thereby possibly lowering an area's wage index value. Consistent with out efforts to finalize the data used to construct the wage index prior to publication of the final rule, we make mid-year data revisions in only very limited circumstances, so that the disruptive effects of such changes can be avoided to the greatest extent possible. In turn, consistent with that principle, we think it is appropriate to limit such mid-year revisions to those pertaining only to the data of the requesting hospital. We do not believe this revision will unduly restrict the ability of hospitals to bring to our attention the need for revisions in a neighboring hospital's data; under our wage data revision process, hospitals have an ample opportunity to do this prior to the publication of the rule. Therefore, we disagree with the commenter that it is necessary or advisable to allow other hospitals an opportunity to request changes to a hospital's wage data after the final rule is published, and we are adopting our proposed changes as final.

Comment: One commenter representing Medicare fiscal intermediaries recommended that we revise the wage index development process to provide an incentive for hospitals to submit accurate wage data with their as-filed cost reports. The

commenter noted that, in the August 1, 2001 **Federal Register** (66 FR 39871), we implemented procedural changes that allow the intermediaries additional time to review hospital's wage data. In that rule, we indicated that wage data were revised between the publication of the proposed and final rules for 30 percent of the hospitals. To reduce this percentage, and the number of ''second'' desk reviews that intermediaries must perform when hospitals revise their wage data, the commenter recommended the following changes:

- CMS should publish an initial wage index public use file in September based on provider as-filed wage data.
- Hospitals should be allowed 4 weeks to review and submit to their intermediaries requests for corrections to the initial wage index public use file.
- After the hospitals 4-week review and correction request period, intermediaries should perform a single desk review of each hospital s wage data and make the appropriate requested corrections.
- After CMS publishes the reviewed final wage index file, hospitals should submit only corrections due to CMS' or the fiscal intermediary's mishandling of the wage data.

Response: We appreciate the commenter's recommendation, and we agree that revisions to the current wage index process should be considered to reduce duplicative review efforts. We will carefully explore options and their associated risks before making further refinements to the wage index development process.

IV. Rebasing and Revision of the Hospital Market Baskets

A. Operating Costs

1. Background

Effective for cost reporting periods beginning on or after July 1, 1979, we developed and adopted a hospital input price index (that is, the hospital ''market basket'') for operating costs. Although ''market basket'' technically describes the mix of goods and services used to produce hospital care, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies combined) derived from that market basket. Accordingly, the term ''market basket'' as used in this document refers to the hospital input price index.

The percentage change in the market basket reflects the average change in the price of goods and services hospitals purchased in order to furnish inpatient care. We first used the market basket to adjust hospital cost limits by an amount that reflected the average increase in the prices of the goods and services used to furnish hospital inpatient care. This approach linked the increase in the cost limits to the efficient utilization of resources.

With the inception of the acute care hospital inpatient prospective payment system, the projected change in the hospital market basket has been the integral component of the update factor by which the prospective payment rates are updated every year. A detailed explanation of the hospital market basket used to develop the prospective payment rates was published in the **Federal Register** on September 3, 1986 (51 FR 31461). We also refer the reader to the August 29, 1997 **Federal Register** (62 FR 45966) in which we discussed the previous rebasing of the hospital input price index. For FY 2003, payment rates will be updated by the projected increase in the hospital market basket minus 0.55 percentage points.

The hospital market basket is a fixed-weight, Laspeyres-type price index that is constructed in three steps. First, a base period is selected and total base period expenditures are estimated for a set of mutually exclusive and exhaustive spending categories based upon type of expenditure. Then, the proportion of total operating costs that each category represents is determined. These proportions are called cost or expenditure weights. Second, each expenditure category is matched to an appropriate price or wage variable, referred to as a price proxy. These price proxies are price levels derived from publicly available statistical series that are published on a consistent schedule, preferably at least on a quarterly basis.

Finally, the expenditure weight for each category is multiplied by the level of the respective price proxy. The sum of these products (that is, the expenditure weights multiplied by the price levels) for all cost categories yields the composite index level of the market basket in a given year. Repeating this step for other years produces a series of market basket index levels over time. Dividing one index level by an earlier index level produces rates of growth in the input price index over that time.

The market basket is described as a fixed-weight index because it answers the question of how much it would cost, at another time, to purchase the same mix of goods and services that was purchased in the base period. The effects on total expenditures resulting from changes in the quantity or mix of goods and services (intensity) purchased subsequent to the base period are not measured. For example, shifting a traditionally inpatient type of care to an outpatient setting might affect the volume of inpatient goods and services purchased by the hospital for use in providing inpatient care, but would not be factored into the price change measured by a fixed weight hospital market basket. In this manner, the index measures only the pure price change. Only rebasing (changing the base year) the index would capture these quantity and intensity effects in the market basket. Therefore, we rebase the market basket periodically so the cost weights reflect changes in the mix of goods and services that hospitals purchase (hospital inputs) in furnishing inpatient care. We last rebased the hospital market basket cost weights in 1997, effective for FY 1998 (62 FR 45993). This market basket, used through FY 2002, reflects base year data from FY 1992 in the construction of the cost weights.

We note that there are separate market baskets for acute care hospital inpatient prospective payment system hospitals and excluded hospitals and hospital units. In addition, we are in the process of conducting the necessary research to determine if separate market baskets for the inpatient rehabilitation, long-term care, and psychiatric hospital prospective payment systems can be developed. However, for the purpose of this preamble, we are only discussing the market basket based on all excluded hospitals combined.

2. Rebasing and Revising the Hospital Market Basket

The terms rebasing and revising, while often used interchangeably, actually denote different activities. Rebasing means moving the base year for the structure of costs of an input price index (for example, the base year cost structure for the prospective payment system hospital index shifts from FY 1992 to FY 1997). Revising means changing data sources, cost categories, or price proxies used in the input price index.

We used a rebased and revised hospital market basket in developing the FY 2003 update factor for the prospective payment rates. The rebased and revised market basket reflects FY 1997, rather than FY 1992, cost data. The 1997-based market baskets use data for hospitals from Medicare cost reports for cost reporting periods beginning on or after October 1, 1996, and before October 1, 1997. Fiscal year 1997 was selected as the new base year because 1997 is the most recent year for which relatively complete data are available. These include data from FY 1997 Medicare cost reports as well as 1997 data from two U.S. Department of

Commerce publications: the Bureau of the Census' Business Expenditure Survey (BES) and the Bureau of Economic Analysis' Annual Input-Output Tables. In addition, analysis of FYs 1998 and 1999 Medicare cost report data showed little difference in comparable cost shares from FY 1997 data.

In developing the rebased and revised market baskets set forth in the May 9, 2002 proposed rule (67 FR 31438) and adopted in this final rule, we used hospital operating expenditure data in determining the market basket cost weights. We relied primarily on Medicare hospital cost report data for the rebasing. We prefer to use cost report data wherever possible because these are the cost data supplied directly from hospitals. Other data sources such as the BES and the input-output tables serve as secondary sources used to fill in where cost report data are not available or appear to be incomplete. We are providing the following detailed discussion of the process for calculating cost share weights.

Cost category weights for the FY 1997-based market baskets were developed in several stages. First, base weights for several of the operating cost categories (Wages and Salaries, Employee Benefits, Contract Labor, Pharmaceuticals, and Blood and Blood Products) were derived from the FY 1997 Medicare cost reports. The expenditures for these categories were calculated as a percentage of total operating costs from those hospitals covered under the inpatient hospital prospective payment system. These data were then edited to remove outliers and ensure that the hospital participated in the Medicare program and had Medicare costs. However, we were unable to measure only those operating costs attributable to the inpatient portion of the hospital because many of the hospitals' cost centers are utilized for both inpatient and outpatient care. Health Economics Research (HER), under contract with CMS, just recently completed a feasibility study on the construction of a separate outpatient market basket for our outpatient hospital prospective payment system. While this research provided some insight about ways to separate inpatient and outpatient costs, HER also found that substantially more data would need to be collected from hospitals in order to accomplish this. Furthermore, we excluded hospital-based subprovider cost centers (for example, skilled nursing, nursing, hospice, psychiatric, rehabilitation, intermediate care/mental retardation, and other long-term care) as well as the portion of overhead and ancillary costs incurred by these subproviders.

Second, the weight for professional liability insurance was calculated using data from a survey conducted by ANASYS under contract to CMS. This survey, called the National Hospital Malpractice Insurance Survey (NHMIS), was conducted to estimate hospital malpractice insurance costs over time at the national level. A more detailed description of this survey is found later in this preamble.

Third, data from the 1997 Business Expenditure Survey (BES) was used to develop a weight for the utilities and telephone services categories. Like most other data sources, the BES includes data for all hospitals and does not break out data by payor. However, we believe the overall data from the BES does not produce results that are inconsistent with the prospective payment system hospitals, particularly at the detailed cost category level with which we are working.

Fourth, the sum of the weights for wages and salaries, employee benefits, contract labor, professional liability insurance, utilities, pharmaceuticals, blood and blood products, and telephone services was subtracted from operating expenses to obtain a portion for all other expenses.

Finally, the weight for all other expenses was divided into subcategories using relative cost shares from the 1997 Annual Input-Output Table for the hospital industry, produced by the Bureau of Economic Analysis, U.S. Department of Commerce. The 1997 Benchmark Input-Output data will be available, at the earliest, in late 2002, so we are unable to incorporate these data in this final rule.

Comment: Several commenters mentioned the need for an improved market basket, where the composition of the market basket is a more contemporary reflection of the cost pressures hospitals are facing. They suggest that we rebase more frequently than the current interval of approximately every 5 years.

Response: As explained in the May 9, 2002 proposed rule (67 FR 31439), FY 1997 was selected as the base year for the revised and rebased hospital market basket because it is the most recent year for which relatively complete data are available.

It is important to realize that the Medicare cost reports were used as the primary source of data because these data were supplied directly from hospitals. The independent secondary sources such as the BES and the input-output table fill in where cost report data were not available or appeared to be incomplete. While the major cost categories are available for a more recent year from the cost reports, the additional detail derived from the input-output tables and the BES was not, as the Bureau of the Census only publishes these data for 5-year intervals. In addition, the major cost category weights determined using the FY 1997 Medicare cost reports were compared to weights calculated using FY 1998 and FY 1999 Medicare cost reports. These results were then compared to the weights calculated from the 1997 Medicare cost reports. The results were very similar to those calculated using FY 1997 Medicare cost report data. Thus, 1997 data are the most recent, complete, and consistent data readily available for our rebasing work this year, and using more recent data woud not produce dissimilar results.

Below, we further describe the sources of the six main category weights and their subcategories in the FY 1997-based market basket while noting the differences between the methodologies used to develop the FY 1992-based and the FY 1997-based market baskets.

- *Wages and Salaries:* The cost weight for the wages and salaries category was derived using Worksheet S–3 from the FY 1997 Medicare cost reports. Contract labor, which is also derived from the FY 1997 Medicare cost reports, is split between the wages and salaries and employee benefits cost categories, using the relationship for employed workers. An example of contract labor is registered nurses who are employed and paid by firms that contract for their work with the hospital. The wages and salaries category in the FY 1992-based market basket was developed from the FY 1992 Medicare cost reports. In addition, we used the 1992 Current Population Survey to break out more detailed occupational subcategories. These subcategories were not broken out for the FY 1997-based market basket.
- *Employee Benefits:* The cost weight for the employee benefits category was derived from Worksheet S–3 of the FY 1997 Medicare cost reports. The employee benefits category in the FY 1992-based market basket was developed from FY 1992 Medicare cost reports and we used the 1992 Current Population Survey to break out various occupational subcategories. These subcategories were not broken out for the FY 1997-based market basket.
- *Nonmedical Professional Fees:* This category refers to various types of nonmedical professional fees such as legal, accounting, engineering, and management and consulting fees. Management and consulting and legal

fees make up the majority of professional fees in the hospital sector. The cost weight for the nonmedical professional fees category was derived from the Bureau of Economic Analysis Input-Output data for 1997. The FY 1992-based index used a combination of data from the American Hospital Association (AHA) and the Medicare cost reports to arrive at a weight. However, because the AHA survey data for professional fees are no longer published, we were unable to duplicate this method. Had we used the FY 1997-based methodology to calculate the FY 1992 nonmedical professional fees component, the proportion would have been similar to the FY 1997 share.

• *Professional Liability Insurance:* The FY 1997-based market basket uses a weight for professional liability insurance derived from a survey conducted by ANASYS under contract to CMS (Contract Number 500–98–005). This survey attempted to estimate hospital malpractice insurance costs over time at the national level for years 1996 and 1997. The population universe of the survey was defined as all non-Federal, short-term, acute care prospective payment system hospitals. A statistical sample of hospitals was drawn from this universe and data collected from those hospitals. This sample of hospitals was then matched to the appropriate cost report data so that a malpractice cost weight could be calculated. The questions used in the survey were based on a 1986 General Accounting Office (GAO) malpractice survey questionnaire that was modified so data could be collected to calculate a malpractice cost weight and the rate of change for a constant level of malpractice coverage at the national level. The 1997 proportion as calculated by ANASYS was compared to limited data for FYs 1998 and 1999 contained in the Medicare Cost Reports System. The percentages are relatively comparable. However, since this field was virtually incomplete in the FY 1997 cost report file, we were unable to use this cost report data.

In contrast, the FY 1992-based market basket professional liability insurance weight was determined using the cost report data for PPS–6 (cost reporting periods beginning in FY 1989), the last year these costs had to be treated separately from all other administrative and general costs, trended forward to FY 1992 based on the relative importance of malpractice costs found in the previous market basket.

Comment: A few commenters indicated that the explanation provided for the derivation of the professional liability insurance weight does not convey a full understanding of the methodology and data used; they would like additional information. They also questioned the appropriateness of assuming a constant level of malpractice coverage at a national level across time when updating this weight.

Response: We believe the method for calculating the weight for professional liability insurance in the hospital market basket is reasonable given the alternatives we examined. The weight for professional liability insurance was derived from a survey conducted by ANASYS for CMS called the National Hospital Malpractice Insurance Survey (NHMIS). This survey was designed to collect hospital malpractice insurance costs of primary and excess coverage as well as deductible and other costs for 1996 and 1997. The survey collected malpractice information directly from a representative sample of hospitals derived from a universe defined as all non-Federal short-term acute care prospective payment system hospitals. The hospitals were sent a questionnaire derived from a 1986 General Accounting Office Survey. Follow-up phone calls were made where necessary resulting in a total response rate to the survey was 67 percent. After the data were collected, several edits were run to test the validity and reasonableness of the data. The total malpractice cost was derived by adding the adjusted primary and excess premiums, deductible costs, and other costs. The survey hospitals were then matched to the corresponding Medicare cost reports to derive a total hospital cost using the malpractice insurance policy year and hospital fiscal year as matching variables. The total professional liability insurance cost for each hospital calculated from the survey was then divided by the total hospital costs calculated from the Medicare cost reports to arrive at a weight for professional liability insurance for the hospital. The mean cost weight of all of the hospital weights was then used as the professional liability insurance weight.

Other methods, such as using the Medicare cost reports or trending 1992 data forward, presented significant data limitations. We were unable to use the Medicare cost report data in the development of a weight because 1997 data were incomplete, with very few hospitals submitting information on professional liability insurance. We compared weights derived from 1998 and 1999 cost report data, which were much more complete than 1997 data, and found that they produced results very similar to the weight calculated in the ANASYS report. We were also unable to use the prior method of calculating a professional liability insurance weight by trending 1992 data forward. This method would only capture the effect of price changes over time and would not reflect increases or decreases in the quantities of professional liability insurance purchased that should be reflected in the cost category weight. In the development of the 1992-based market basket, the method used was the only available option. Therefore, given the data available from ANASYS and the limitations of other methods we considered, we believe that the method of calculating a weight chosen was reasonable.

To address the commenters' second point, we feel that it is appropriate to assume a constant level of malpractice coverage at a national level. By doing so, we are able to capture only the 'pure' price change in professional liability premiums and not the additional effect of increasing or decreasing liability coverage. This method is consistent with the methods used by Bureau of Labor Statistics (BLS) in constructing its Producer Price Indexes (PPIs).

Comment: Several commenters believe that we should explicitly account for other insurance categories such as property and general liability insurance in the market basket and not just professional liability insurance because of large premium increases in those categories. In addition, the commenters believe that we should adjust the weight given to insurance, blood products, and other items that experience extraordinary price increases.

Response: The market basket implicitly accounts for increases in other insurance categories under the All Other-Labor Intensive Services category. We are unable to separate out other detailed insurance categories in the market basket due to data limitations. A publicly available data source that meets our criteria for developing weights for these other insurance categories does not exist at this time. In addition, data for price proxies such as the BLS PPI for property and casualty insurance show similar price movements to those of the All Other-Labor Intensive category in the market basket.

In addition, we cannot inflate the weights of some categories and not others. This would violate the general principles of price index construction. We have compiled data for all of the cost categories in addition to total costs for a common base year and developed a set of weights that are consistent with respect to the principles of price index construction. Attempting to reflect more

recent trends in some categories and not in others would not accurately capture the entire cost structure that hospitals face at a given time. In addition, while expenditures for a category may be increasing, this may not necessarily lead to a greater weight for that category in the market basket. For example, property insurance expenditures could be increasing, but other categories could be increasing faster, so that the weight for property insurance in the market basket would be declining. Thus, it is necessary that all of the weights are reflective of a consistent base year.

• *Utilities:* For the FY 1997-based market baskets, the cost weight for utilities is derived from the Bureau of the Census' Business Expenditures Survey. For the FY 1992-based market baskets, the cost weight for utilities was derived from the Bureau of the Census' Asset and Expenditures Survey. Even though the Business Expenditure Survey replaced the Asset and Expenditure Survey, the categories and results are still similar.

• *All Other Products and Services:* The all other products and services category includes the remainder of products and services that hospitals purchase in providing care. Products found in this category include: direct service food, contract service food, pharmaceuticals, blood and blood products, chemicals, medical instruments, photographic supplies, rubber and plastics, paper products, apparel, machinery and equipment, and miscellaneous products. Services found in this category include: telephone, postage, other labor-intensive services, and other nonlabor-intensive services. Labor-intensive services include those services for which local labor markets would likely influence prices.

The shares for pharmaceuticals and blood and blood products are derived from the FY 1997 Medicare cost reports, while the share for telephone services was derived from the BES. Relative shares for the other subcategories are derived from the 1997 Bureau of Economic Analysis Annual Input-Output Table for the hospital industry. The calculation of these subcategories involved calculating a residual from the Input-Output Table using categories similar to those not yet accounted for in the market basket. Subcategory weights were then calculated as a proportion of this residual and applied to the similar residual in the market basket.

• *Blood and blood products:* When the market basket was last revised and rebased to FY 1992, the component for blood services was discontinued because of the lack of appropriate data to determine a weight. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) required that we consider the prices of blood and blood products purchased by hospitals and determine whether those prices are adequately reflected in the market basket. In accordance with this requirement, we have done considerable research to determine if a component for blood and blood products should be added to the market basket and, if so, how the weight should be determined. We studied four alternative data sources to possibly determine a weight for blood in the market basket. If none of these data sources were deemed acceptable, we could conclude that a component for blood should not be reintroduced in the hospital market basket. In its December 2001 report entitled ''Blood Safety in Hospitals and Medicare Inpatient Payment,'' MedPAC recommended that the market basket should explicitly account for the cost of blood and blood products by reintroducing a separate component for their prices.

The first alternative data source studied was using data from the Medicare cost reports. The cost reports have two cost centers where the costs of blood can be recorded: (1) Whole blood and packed red blood cells (nonsalary); and (2) blood storing, processing, and transfusion (nonsalary). Although all prospective payment system hospitals submit a cost report, less than half of these hospitals reported data in either of the two blood cost centers. However, if we can determine that the hospitals reporting blood are representative of all prospective payment system hospitals, then a cost share can be computed using the cost reports.

The second alternative involves constructing weights from the Input-Output Table from the BEA, Department of Commerce. These data were used to construct the weight when the market basket was revised before FY 1992. Unfortunately, BEA stopped reporting blood separately in their Input-Output Table in 1987. One possible use of these data would be to calculate a weight by updating the prior weight by the relative price change for blood between the last data point available and 1997. However, by using this method, only the escalation in prices, not the changes in quantity or intensity of use of blood products, would be captured.

The third alternative was using data from the MedPAR files. This option was discussed in MedPAC's December 2001 report, and involves using claims data or data on hospital charges. In order to construct a weight for the market basket, the underlying costs of blood must be calculated from the claims data. An analysis of cost-to-charge ratios of hospitals can determine if this is feasible.

The final alternative data source is the Bureau of the Census' quinquennial Business Expenditure Survey and the Economic Census. A weight can be obtained indirectly by taking the ratio of receipts of nonprofit blood collectors to total operating expenses of hospitals. Some adjustments would be needed in order for the weight calculated in this way to be completely valid. In addition, this method assumes that all blood used by hospitals comes from nonprofit sources. However, in 1999, hospitals collected 7 percent of the donated units.

After a thorough analysis, we have determined that the Medicare cost reports, after minor adjustments, are the best option. The data from the Input-Output Table are not optimal because they are not current and would have to be aged using only price data, which do not reflect quantity and intensity changes over this period. Although the MedPAR data could be adjusted to compute a cost share, using claims data is not the preferred alternative. Census data would be an attractive option if the cost reports were not available.

The main weakness of the Medicare cost reports is the inconsistent reporting of hospitals in the two blood cost centers. In 1997, only 48.0 percent of all hospitals reported blood in one or both cost centers. However, these hospitals accounted for 62.2 percent of the operating costs of all hospitals. In order for the calculation of the blood cost share weight to be acceptable, the hospitals that reported blood would need to be adjusted to be representative of all hospitals, including those that did not report blood on the cost reports.

Because of the similarity of data in the two blood cost centers, the assumption was made that if a hospital reported blood in only one of the two cost centers, all of its blood costs were reported in that cost center. In the FY 1997 cost reports, of the hospitals that reported blood, 41.3 percent reported only in the blood cells cost center, 58.2 percent reported only in the blood storing cost center, and only 0.5 percent reported in both blood cost centers. To calculate a weight, the numerator was the summation of the data in both blood cost centers. The denominator was the summation of the operating costs of each hospital that reported blood in each cost center minus the operating costs of the few hospitals that reported blood in both cost centers to avoid double counting.

The blood cost share calculated from these data was then adjusted so that the hospitals reporting blood had the same

characteristics of all other hospitals. Adjustments were necessary because the hospitals that reported blood were more likely to be urban and teaching hospitals than those hospitals that did not report blood. The adjustments made less than a 0.1 percent difference in the cost share.

The weight produced using the FY 1997 cost reports was 0.875 percent. We also looked at cost report data from FYs 1996 and 1998. The weights calculated in these years were similar to the FY 1997 weight. The calculation of the blood cost share using the alternative data sources cited above was similar to the results using the cost reports. In this final rule, we use the Medicare cost reports to determine a weight for blood and blood products in the hospital market basket given the consistency with these other sources, the representativeness of our estimate, and the stability of the cost share.

Overall, our work resulted in the identification of 23 separate cost categories in the rebased and revised hospital market basket. There is one more category than was included in the FY 1992-based market basket (FY 1992-based had 22 categories). The differences between the weights of the major categories determined from the Medicare cost reports for the FY 1997-based index and the previous FY 1992-based index are summarized in Table 1.

TABLE 1.—FY 1992-BASED AND FY 1997-BASED PROSPECTIVE PAYMENT SYSTEM HOSPITAL OPERATING MAJOR COST CATEGORIES AND WEIGHTS AS DETERMINED FROM THE MEDICARE COST REPORTS

Expense categories	Rebased FY 1997-based hospital market basket	FY 1992-Based hospital market basket
Wages and Salaries	50.686	50.244
Employee Benefits	10.970	11.146
Pharmaceuticals	5.416	4.162
Blood and Blood Products	0.875	.....
All Other	32.053	34.448
Total	100.000	100.000

Table 2 sets forth all of the market basket cost categories and weights. For comparison purposes, the 1992-based cost categories and weights are included in the table.

TABLE 2.—FY 1992-BASED AND FY 1997-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING COST CATEGORIES AND WEIGHTS

Expense categories	Rebased FY 1997-based hospital market basket weights	FY 1992-based hospital market basket weights
1. Compensation	61.656	61.390
A. Wages and Salaries	50.686	50.244
B. Employee Benefits	10.970	11.146
2. Professional Fees	5.401	2.127
3. Utilities	1.353	1.542
A. Fuel, Oil, and Gasoline	0.284	0.369
B. Electricity	0.833	0.927
C. Water and Sewerage	0.236	0.246
4. Professional Liability Insurance	0.840	1.189
5. All Other	30.749	33.752
A. All Other Products	19.537	24.825
(1.) Pharmaceuticals	5.416	4.162
(2.) Direct Purchase Food	1.370	2.314
(3.) Contract Service Food	1.274	1.072
(4.) Chemicals	2.604	3.666
(5.) Blood and Blood Products	0.875	.....
(6.) Medical Instruments	2.192	3.080
(7.) Photographic Supplies	0.204	0.391
(8.) Rubber and Plastics	1.668	4.750
(9.) Paper Products	1.355	2.078
(10.) Apparel	0.583	0.869
(11.) Machinery and Equipment	1.040	0.207
(12.) Miscellaneous Products	0.956	2.236
B. All Other Services	11.212	8.927
(1.) Telephone Services	0.398	0.581
(2.) Postage	0.857	0.272
(3.) All Other: Labor Intensive	5.438	7.277
(4.) All Other: Non-Labor Intensive	4.519	0.796
Total	100.000	100.000

Note: Due to rounding, weights may not sum to total.

3. Selection of Price Proxies

After computing the FY 1997 cost weights for the rebased and revised hospital market basket, it was necessary to select appropriate wage and price proxies for each expenditure category. Most of the indicators are based on BLS data and are grouped into one of the following BLS categories:

• Producer Price Indexes—Producer Price Indexes (PPIs) measure price changes for goods sold in other than retail markets. PPIs are preferable price proxies for goods that hospitals purchase as inputs in producing their outputs because a PPI would better reflect the prices faced by hospitals. For example, we used the PPI for ethical (prescription) drugs, rather than the Consumer Price Index (CPI) for prescription drugs, because hospitals generally purchase drugs directly from the wholesaler. The PPIs that we use measure price changes at the final stage of production.

• Consumer Price Indexes—Consumer Price Indexes (CPIs) measure price changes of final goods and services bought by the typical consumer. Because they may not represent the price faced by a producer, the consumer price indexes were used only if an appropriate PPI was not available or if the expenditure was more similar to that of retail consumers in general rather than wholesale purchasers. For example, the CPI for food purchased away from home was used as a proxy for contracted food services.

• Employment Cost Indexes—Employment Cost Indexes (ECIs) measure the rate of change in employee wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. They are appropriately not affected by shifts in skill mix.

Table 3 sets forth the complete hospital market basket including cost categories, weights, and price proxies. For comparison purposes, we also list the respective FY 1992-based market basket price proxies. A summary outlining the choice of the various proxies follows the table.

TABLE 3.—FY 1997-BASED PROSPECTIVE PAYMENT SYSTEM HOSPITAL OPERATING COST CATEGORIES AND WEIGHTS, AND FY 1992-BASED AND FY 1997-BASED PRICE PROXIES

Expense categories	Rebased FY 1997 hospital market basket weights	Rebased FY 1997 hospital market basket price proxy	FY 1992 hospital market basket price proxy
1. Compensation	61.656		
Wages and Salaries	50.686	ECI-Wages and Salaries, Civilian Hospital Workers.	CMS Occupational Wage Proxy
Employee benefits	10.970	ECI-Benefits, Civilian Hospital Workers	CMS Occupational Benefit Proxy
2. Professional Fees	5.401	ECI-Compensation for Professional, Specialty & Technical.	ECI-Compensation for Professional, Specialty & Technical
3. Utilities	1.353		
A. Fuel, Oil, And Gasoline	0.284	PPI Commercial Natural Gas	PPI Commercial Natural Gas
B. Electricity	0.833	PPI Commercial Electric Power	PPI Commercial Electric Power
C. Water and Sewerage	0.236	CPI–U Water & Sewerage Maintenance.	CPI–U Water & Sewerage Maintenance
4. Professional Liability Insurance	0.840	CMS Professional Liability Insurance Premium Index.	CMS Professional Liability Insurance Premium Index
5. All Other	30.749		
All Other Products	19.537		
(1.) Pharmaceuticals	5.416	PPI Ethical (Prescription) Drugs	PPI Ethical (Prescription) Drugs
(2.) Direct Purchase Food	1.370	PPI Processed Foods & Feeds	PPI Processed Foods & Feeds
(3.) Contract Service Food	1.274	CPI–U Food Away From Home	CPI–U Food Away From Home
(4.) Chemicals	2.604	PPI Industrial Chemicals	PPI Industrial Chemicals
(5.) Blood and Blood Products	0.875	PPI Blood and Blood Derivatives, Human Use.	N/A
(6.) Medical Instruments	2.192	PPI Medical Instruments & Equipment	PPI Medical Instruments & Equipment
(7.) Photographic Supplies	0.204	PPI Photographic Supplies	PPI Photographic Supplies
(8.) Rubber and Plastics	1.668	PPI Rubber & Plastic Products	PPI Rubber & Plastic Products
(9.) Paper Products	1.355	PPI Converted Paper & Paperboard Products.	PPI Converted Paper & Paperboard Products
(10.) Apparel	0.583	PPI Apparel	PPI Apparel
(11.) Machinery and Equipment.	1.040	PPI Machinery & Equipment	PPI Machinery & Equipment
(12.) Miscellaneous Products	0.956	PPI Finished Goods less Food and Energy.	PPI Finished Goods
B. All Other Services	11.212		
(1.) Telephone Services	0.398	CPI–U Telephone Services	CPI–U Telephone Services
(2.) Postage	0.857	CPI–U Postage	CPI–U Postage
(3.) All Other: Labor Intensive	5.438	ECI-Compensation for Private Service Occupations.	ECI-Compensation for Private Service Occupations
(4.) All Other: Non-Labor Intensive.	4.519	CPI–U All Items	CPI–U All Items
Total	100.000		

Note: Totals may not sum to 100 due to rounding.

a. Wages and Salaries

For measuring the price growth of wages in the FY 1997-based market basket, we use the ECI for civilian hospitals. This differs from the proxy used in the FY 1992-based index in which a blended occupational wage index was used. The blended occupational wage proxy used in the FY 1992-based index and the ECI for wages and salaries for hospitals both reflect a fixed distribution of occupations within the hospital. The major difference between the two proxies is in the treatment of professional and technical wages. In the blended occupational wage proxy, the professional and technical category was blended evenly between the ECI for wages and salaries for hospitals and the ECI for wages and salaries for professional and technical occupations in the overall economy, instead of hospital-specific occupations as reflected in the ECI for hospitals. This blend was done to create a normative price index that did not reflect the market imperfections in the hospital labor markets that existed for much of the 1980s and early 1990s.

Between 1987 (the first year the ECI for hospitals was available, although the pattern existed before then using other measures of hospital wages) and 1994, the ECI for wages and salaries for hospital workers grew faster than the blended occupational wage proxy. During the period from 1995 through 2000, this trend reversed; each year the ECI grew slower than the blended occupational wage proxy. This is the apparent result of the shift of private insurance enrollees from fee-for-service plans to managed care plans and the tighter controls these plans exhibited over hospital utilization and incentives to shift care out of the inpatient hospital setting. More recently, the ECI for wages and salaries for hospital workers has again grown faster than the blended occupational wage proxy, raising the question of whether the relationship between hospital wages and the occupational wage blend from 1994 through 2000 was the signaling of a new era in the competitiveness of the hospital labor market, or simply the temporary reversal of the long-term pattern of labor market imperfections in hospitals.

In order to answer this question, we researched the historical determinants of this relationship and estimated what the future market conditions are likely to be. Our analysis indicated that the driving force behind the long-term differential between hospital wages and the blended occupational wage proxy was the increased demand for hospital services and the subsequent increase in hospital utilization, particularly in outpatient settings. However, during the 1994 through 2000 period, the major force behind the reversal of the differential was the shift of enrollees to managed care plans that had tighter restrictions on hospital utilization and encouraged the shift of care out of the hospital setting. To a lesser extent, the robust economic growth and tight economy-wide labor markets that accompanied this period helped to reverse the differential as well. Over the last few years, there has been a move back towards less restrictive plans, and a subsequent increase in the utilization of hospital services. This recent surge appears to reflect the true underlying effect of rising health care demand.

This concept is reinforced by the similar patterns being observed for nursing homes and other health sectors as well. This is an important development, specifically when compared to the ECI for wages and salaries for nursing homes, which reflect less skilled occupations, yet still experienced a similar acceleration in wage growth. Thus, we would expect that this recent surge in hospital wages is reflective of competitive labor market conditions, and would likely persist only as long as the underlying demand for health care was accelerating.

While the shift to managed care plans had a noticeable one-time effect, our analysis has indicated that the hospital labor market is more competitive than before this period and that the expected shift towards more restrictive insurance plans over the coming decade will act to create a wage differential that reflects the underlying increases in demand for hospital services. For FY 2003, the hospital market basket is forecast to increase 0.2 percentage points faster (3.5 versus 3.3) than it would have if the occupational blend had been used. Based on this, we use the ECI for wages and salaries for hospitals as the proxy in the hospital market basket for wages. The ECI met our criteria of relevance, reliability, availability, and timeliness. Relevance means that the proxy is applicable and representative of the cost category that it proxies. Reliability indicates that the index is based on valid statistical methods and has low sampling variability. Availability means that the proxy is publicly available. Timeliness implies that the proxy is published regularly, at least quarterly.

b. Employee Benefits

The FY 1997-based hospital market basket uses the ECI for employee benefits for civilian hospitals. This differs from the FY 1992-based index in which a blended occupational index was used. Our conclusions were based on an analysis similar to that done for the wages and salaries proxy described above.

c. Nonmedical Professional Fees

The ECI for compensation for professional and technical workers in private industry is applied to this category since it includes occupations such as management and consulting, legal, accounting, and engineering services. The same price measure was used in the FY 1992-based market basket.

d. Fuel, Oil, and Gasoline

The percentage change in the price of gas fuels as measured by the PPI (Commodity Code #0552) is applied to this component. The same price measure was used in the FY 1992-based market basket.

e. Electricity

The percentage change in the price of commercial electric power as measured by the PPI (Commodity Code #0542) is applied to this component. The same price measure was used in the FY 1992-based market basket.

f. Water and Sewerage

The percentage change in the price of water and sewerage maintenance as measured by the Consumer Price Index (CPI) for all urban consumers (CPI Code #CUUR0000SEHG01) is applied to this component. The same price measure was used in the FY 1992-based market basket.

g. Professional Liability Insurance

The percentage change in the hospital professional liability insurance price as estimated by the CMS Hospital Malpractice Index is applied. In the FY 1992-based market basket, the same proxy was used.

We are currently conducting research into improving our proxy for professional liability insurance. This research includes subcontracting with ANASYS through a contract with DRI–WEFA to extend the results of its NHMIS survey to set up a sample of hospitals from which malpractice insurance premium data will be directly collected. This new information, which would include liability estimates for hospitals that self-insure, would be combined with our current proxy data to obtain a more accurate price measure. In addition, we continue to monitor a BLS PPI for medical malpractice premiums that in the future could be used as a proxy for this cost category.

Comment: Several commenters indicated that hospital malpractice costs are increasing much faster than the professional liability portion of the market basket and we should consider other alternatives.

Response: We believe that our price proxy for professional liability insurance adequately measures the increases in professional liability insurance costs facing hospitals. While anecdotal evidence suggests that malpractice costs are increasing at double-digit rates, actual data as measured by the CMS hospital professional liability insurance survey as well as data on insurance from the BLS Producer Price Index through 2001 do not reflect this. Since the FY 2003 market basket increase is based on a forecast from DRI–WEFA, the expected trends in hospital professional liability insurance premiums are indeed reflected. As is the case with all of our indexes, we regularly review all of the proxies in the index to verify that they are representative of current industry trends. In addition, as mentioned in the May 9, 2002 proposed rule (67 FR 31444), we are currently exploring alternatives to our price proxy for hospital professional liability insurance including possibly using the BLS Producer Price Index for medical malpractice. We are also working with our contractor to explore possible methods of improving our hospital professional liability proxy, though this research is not yet complete.

h. Pharmaceuticals

The percentage change in the price of prescription drugs as measured by the PPI (Commodity Code #PPI283D#RX) is applied to this variable. This is a special index produced by BLS. The previous price proxy used in the FY 1992-based index (Commodity Code #0635) was discontinued after BLS revised its indexes.

i. Food, Direct Purchases

The percentage change in the price of processed foods as measured by the PPI (Commodity Code #02) is applied to this component. The same price measure was used in the FY 1992-based market basket.

j. Food, Contract Services

The percentage change in the price of food purchased away from home as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEFV) is applied to this component. The same price measure was used in the FY 1992-based market basket.

k. Chemicals

The percentage change in the price of industrial chemical products as measured by the PPI (Commodity Code #061) is applied to this component. While the chemicals hospitals use include industrial as well as other types of chemicals, the industrial chemicals component constitutes the largest proportion by far. Thus, Commodity Code #061 is the appropriate proxy. The same price measure was used in the FY 1992-based market basket.

l. Blood and Blood Products

The percentage change in the price of blood and derivatives for human use as measured by the PPI (Commodity Code #063711) is applied to this component. As discussed earlier in this preamble, a comparable cost category was not available in the FY 1992-based market basket.

We use the PPI for blood and blood derivatives as the price proxy for the blood and blood products cost category. This proxy is relevant, reliable, available, and timely. We considered placing the blood weight in the Chemicals or Pharmaceuticals cost category, but found this made only minor changes to the total index. We also considered constructing an index based on blood cost data received from the American Red Cross, America's Blood Centers, and Zeman and Company. However, these data are collected annually and are not widely available. The PPI for blood and blood derivatives was the only index we found that met all of our criteria.

Comment: Several commenters supported the separate expense category for blood and blood products in the market basket and the use of the PPI for blood and blood derivatives for human use as the price proxy for monitoring the rate of change in blood costs. However, the commenters indicated that it is important to ensure that the PPI for blood and blood derivatives is appropriately and timely updated by the BLS so that it adequately tracks changing blood technologies and safety initiatives. The commenters added that ensuring the safety of the nation's blood supply requires constant attention to developing disease states and testing technologies and creates changing costs that must be captured by the blood PPI to ensure adequate reflection in the prospective payment system market basket.

Response: We agree that the PPI for blood and blood derivatives should appropriately reflect the price of blood and blood products. We will continue to monitor the PPI to ensure that this is the case. We are supportive of efforts by the BLS to collect the necessary information on the price of blood and blood products so they are accurately reflected in the PPI for blood and blood derivatives. Organizations that represent blood providers are also encouraged to work with BLS to accomplish this goal.

Comment: One commenter suggested that we use data from the Red Cross, America's Blood Centers or Zeman and Company in developing a price proxy that reflects recent cost increases for blood products.

Response: We require that all price indexes used in our market baskets to be relevant, reliable, available, and timely. The BLS PPI for blood and blood derivatives is an independent estimate of prices for these products that are published on a regular schedule (monthly). It is based on sound statistical methods and meets our criteria listed above. The possible sources of data mentioned by the commenter are not available frequently enough and on a regular basis and, therefore, do not meet the criterion of timeliness. Also, it has not been determined if indexes based on these data would be relevant or reliable enough for use in the CMS market baskets. Furthermore, because of their method of construction, the BLS indexes that we use as price proxies in the market baskets reflect only the effect of price changes and not the effects of quantity or quality changes. Our market baskets are designed to measure only the price change effects on increases in costs and not the quantity or quality effects. It has not been demonstrated whether indexes from these other data sources would capture only price effects or whether they mix price and quantity/quality effects.

m. Surgical and Medical Equipment

The percentage change in the price of medical and surgical instruments as measured by the PPI (Commodity Code #1562) is applied to this component. The same price measure was used in the FY 1992-based market basket.

n. Photographic Supplies

The percentage change in the price of photographic supplies as measured by the PPI (Commodity Code #1542) is applied to this component. The same price measure was used in the FY 1992-based market basket.

o. Rubber and Plastics

The percentage change in the price of rubber and plastic products as measured by the PPI (Commodity Code #07) is applied to this component. The same

price measure was used in the FY 1992-based market basket.

p. Paper Products

The percentage change in the price of converted paper and paperboard products as measured by the PPI (Commodity Code #0915) is used. The same price measure was used in the FY 1992-based market basket.

q. Apparel

The percentage change in the price of apparel as measured by the PPI (Commodity Code #381) is applied to this component. The same price measure was used in the FY 1992-based market basket.

r. Machinery and Equipment

The percentage change in the price of machinery and equipment as measured by the PPI (Commodity Code #11) is applied to this component. The same price measure was used in the FY 1992-based market basket.

s. Miscellaneous Products

The percentage change in the price of all finished goods less food and energy as measured by the PPI (Commodity Code #SOP3500) is applied to this component. The percentage change in the price of all finished goods was used in the FY 1992-based market basket. This change was made to remove the effect of food and energy prices, which are already captured elsewhere in the market basket.

t. Telephone

The percentage change in the price of telephone services as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEED) is applied to this component. The same price measure was used in the FY 1992-based market basket.

u. Postage

The percentage change in the price of postage as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEEC01) is applied to this component. The same price measure was used in the FY 1992-based market basket.

v. All Other Services, Labor Intensive

The percentage change in the ECI for compensation paid to service workers employed in private industry is applied to this component. The same price measure was used in the FY 1992-based market basket.

w. All Other Services, Nonlabor Intensive

The percentage change in the all-items component of the CPI for all urban consumers (CPI Code #CUUR0000SA0) is applied to this component. The same price measure was used in the FY 1992-based market basket.

For further discussion of the rationale for choosing many of the specific price proxies, we reference the August 30, 1996 final rule (61 FR 46326). Table 4 shows the historical and forecasted updates under both the FY 1997-based and the FY 1992-based market baskets.

TABLE 4.—FY 1992-BASED AND FY 1997-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING INDEX PERCENT CHANGE, 1995–2004

Fiscal year (FY)	Rebased 1997-based hospital market basket	FY 1992-based market basket
Historical Data:		
FY 1995	2.8	3.1
FY 1996	2.3	2.4
FY 1997	1.6	2.1
FY 1998	2.7	2.9
FY 1999	2.7	2.5
FY 2000	3.3	3.6
FY 2001	4.3	4.1
Average FYs 1995–2001	2.8	3.0
Forecast:		
FY 2002	3.9	3.0
FY 2003	3.5	3.2
FY 2004	3.1	3.2
Average FYs 2002–2004	3.5	3.1

Source: Global Insights, Inc, DRI–WEFA, 2nd Qtr. 2002; @USMACRO/MODTREND @CISSIM/TL0502.SIM

As indicated by Table 5, switching the proxy for wages and benefits to the ECI for Civilian Hospitals has a minimal effect over time. While the FY 2003 update is 0.2 percentage points higher than using the previous blended occupational wage proxy, we believe that it is a more appropriate measure of price change in hospital wages and benefit prices given the current labor market conditions facing hospitals.

TABLE 5.—1997-BASED PROSPECTIVE PAYMENT SYSTEM HOSPITAL OPERATING INDEX PERCENT CHANGE, USING DIFFERENT WAGE AND BENEFIT PROXIES, 1995–2004

Fiscal year (FY)	Rebased 1997 hospital market basket using ECIs for wages and benefits	Rebased 1997 market basket using occupational wage and benefit proxies
Historical Data:		

TABLE 5.—1997-BASED PROSPECTIVE PAYMENT SYSTEM HOSPITAL OPERATING INDEX PERCENT CHANGE, USING DIFFERENT WAGE AND BENEFIT PROXIES, 1995–2004—Continued

Fiscal year (FY)	Rebased 1997 hospital market basket using ECIs for wages and benefits	Rebased 1997 market basket using occupational wage and benefit proxies
FY 1995	2.8	3.0
FY 1996	2.3	2.5
FY 1997	1.6	2.2
FY 1998	2.7	3.2
FY 1999	2.7	3.0
FY 2000	3.3	3.4
FY 2001	4.3	4.1
Average FYs 1995–2001	2.8	3.1
Forecast:		
FY 2002	3.9	3.3
FY 2003	3.5	3.3
FY 2004	3.1	3.3
Average FYs 2002–2004	3.5	3.3

Source: Global Insights, Inc, DRI–WEFA, 2nd Qtr. 2002; @USMACRO/MODTREND @CISSIM/TL0502.SIM

4. Labor-Related Share

Sections 1886(d)(2)(H) and (d)(3)(E) of the Act direct the Secretary to estimate from time to time the proportion of payments that are labor-related: ''The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates * * *.'' The labor-related share is used to determine the proportion of the national prospective payment system base payment rate to which the area wage index is applied. In the past, we have defined the labor-related share for prospective payment system acute care hospitals as the national average proportion of operating costs that are related to, influenced by, or vary with the local labor market. The labor-related share for the acute care hospital inpatient prospective payment system market basket has been the sum of the weights for wages and salaries, fringe benefits, professional fees, contract labor, postage, business services, and labor-intensive services.

In its June 2001 Report to Congress, MedPAC recommended that ''To ensure accurate input-price adjustments in Medicare's prospective payment systems, the Secretary should reevaluate current assumptions about the proportions of providers' costs that reflect resources purchased in local and national markets.'' (Report to the Congress: Medicare in Rural America, p. 80, Recommendation 4D.) MedPAC believes that the labor-related share is an estimate of the national average proportion of providers' costs associated with inputs that are only affected by local market wage levels. MedPAC recommended the labor-related share include the weights for wages and salaries, fringe benefits, contract labor, and other labor-related costs for locally purchased inputs only. By changing the methodology, and thereby lowering the labor-related share, funds would be transferred from urban to rural hospitals, which generally have wage index values less than 1.0.

Our proposed methodology was consistent with that used in the past to determine the labor-related share, which is the summation of the cost categories from the market basket deemed to vary with the local labor market. However, we noted that, while we did not propose to change the methodology for calculating the labor-related share in the proposed rule, we have begun the research necessary to reevaluate the current assumptions used in determining this share. This reevaluation is consistent with MedPAC's recommendation in their June 2001 report. Our research involves analyzing the compensation share separately for urban and rural hospitals, using regression analysis to determine the proportion of costs influenced by the area wage index, and exploring alternative methodologies to determine whether all or just a portion of professional fees and nonlabor intensive services should be considered labor-related.

We also noted our concern that the result of our methodology (increasing the labor-related share from 71.066 percent to 72.495 percent) could have negative impacts that would fall predominantly on rural hospitals. In addition, we noted that we planned to conduct further research and would make the appropriate changes in the final rule if another methodology was found to be superior to our current methodology.

Comment: Commenters generally supported our expressed willingness to review this methodology, and emphasized the need for a full and careful study of any changes before adopting major changes. Comments on behalf of some national and State hospital associations recommended that we not make any change to the labor-related share calculation, while proceeding with market basket rebasing, until completing a more thorough examination of the proportion of labor costs influenced by the local labor market, noting that we included in our methodology costs related to, influenced by, or that vary with the local labor market, even if these services may be purchased at the national level.

MedPAC commented that it believes that certain expenditures identified in our methodology as locally purchased are in fact purchased, in whole or in part, in national markets. The Commission gave examples such as computing, legal, and accounting services. The Commission noted it has worked with us in the past to discuss these issues, and commented that continued use of our proposed approach is appropriate in the absence of a superior method. Several commenters referred to the difference between MedPAC's and CMS's methodologies and suggested that we should adopt MedPAC's methodology.

Other commenters argued the labor-related share must be decreased, noting that increasing the percentage will only exacerbate current flaws in the payment system. Some commenters referred to the fact that the outpatient prospective payment system labor-related share is only 60 percent. Another commenter suggested the labor-related share should be changed to a State-specific share.

Still other commenters, some of whom represent national and State hospital associations, supported the proposed methodology, and expressed their belief that any revised methodology from the one discussed in the proposed rule would need to be separately proposed with an opportunity for specific public comment. It was also noted that it has been our standard practice to empirically estimate the labor share in accordance with changes in the market basket, and it was recommended that we continue to follow our empirical estimate. Another commenter stated that our proposed methodology is consistent with both our past practice and statutory mandate.

Response: We have decided not to proceed with reestimating the labor-related share at this time. We will conduct further analysis to determine the most appropriate methodology before proceeding. Therefore, for FY 2003, the labor-related share applicable to the standardized amounts will remain at 71.066 percent. Any future revisions to the labor-related share or the methodology will be proposed and subject to public comment.

We appreciate the input from commenters on this issue, and look forward to continuing to work with MedPAC and the hospital industry on future refinements to the labor-related share methodology.

Comment: One commenter offered several specific refinements to the proposed methodology. The commenter agreed with our proposal to remove postage costs from the methodology and recommended that insurance costs and certain other wage-related costs also be removed.

Another commenter noted that we are adjusting the labor portion of the standardized amount using data that is not measured through the existing hospital wage index. The commenter reports estimating a labor share of 61.656 percent by excluding contract labor costs not included in the wage index.

Response: As noted above, we are not revising our estimate of the labor-related share at this time. We will take these comments into consideration in our future analysis.

5. Separate Market Basket for Hospitals and Hospital Units Excluded From the Acute Care Hospital Inpatient Prospective Payment System

In its March 1, 1990 report, ProPAC recommended that we establish a separate market basket for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system. Effective with FY 1991, we adopted ProPAC's recommendation to implement separate market baskets. (See the September 4, 1990 final rule (55 FR 36049).) Prospective payment system hospitals and excluded hospitals and units tend to have different case mixes, practice patterns, and composition of inputs. The fact that excluded hospitals are not included under the acute care hospital inpatient prospective payment system in part reflects these differences. Studies completed by HCFA (now CMS), ProPAC, and the hospital industry have documented different weights for excluded hospitals and units and prospective payment system hospitals.

The excluded hospital market basket is a composite set of weights for Medicare-participating psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. We use cost report data for excluded freestanding hospitals whose Medicare average length of stay is within 15 percent (that is, 15 percent higher or lower) of the total facility average length of stay for excluded hospitals, except psychiatric hospitals. A tighter measure of Medicare length of stay within 8 percent (that is, 8 percent higher or lower) of the total facility average length of stay is used for freestanding psychiatric hospitals. This is done because psychiatric hospitals have a relatively small proportion of costs from Medicare and a relatively small share of Medicare psychiatric cases. While the 15-percent length of stay edit was used for the FY 1992-based index, the tighter 8-percent edit for psychiatric hospitals was not. We believe that limiting our sample to hospitals with a Medicare average length of stay within a comparable range to the total facility average length of stay provides a more accurate reflection of the structure of costs for treating Medicare patients.

Table 6 compares major weights in the rebased FY 1997 market basket for excluded hospitals with weights in the rebased FY 1997 market basket for acute care prospective payment system hospitals. Wages and salaries are 51.998 percent of total operating costs for excluded hospitals compared to 50.686 percent for acute care prospective payment hospitals. Employee benefits are 11.253 percent for excluded hospitals compared to 10.970 percent for acute care prospective payment hospitals. As a result, compensation costs (wages and salaries plus employee benefits) for excluded hospitals are 63.251 percent of costs compared to 61.656 percent for acute care prospective payment hospitals, reflecting the more labor-intensive services conducted in excluded hospitals.

A significant difference in the category weights also occurs in pharmaceuticals. Pharmaceuticals represent 5.416 percent of costs for acute care prospective payment hospitals and 6.940 percent for excluded hospitals. The weight for the excluded hospital market basket was derived using the same data sources and methods as for the acute care prospective payment market basket which were outlined previously. Differences in weights between the excluded hospital and acute care prospective payment hospital market baskets do not necessarily lead to significant differences in the rate of price growth for the two market baskets. If individual wages and prices move at approximately the same annual rate, both market baskets may have about the same overall price growth, even though the weights may differ substantially, because both market baskets use the same wage and price proxies. Also, offsetting price increases for various cost components can result in similar composite price growth in both market baskets.

TABLE 6.—FY 1997-BASED EXCLUDED HOSPITAL AND PROSPECTIVE PAYMENT SYSTEM HOSPITAL MARKET BASKETS, COMPARISON OF SIGNIFICANT WEIGHTS

Category	Rebased FY 1997-based excluded hospital market basket	Rebased FY 1997-based prospective payment system hospital market basket
Wages and Salaries	51.998	50.686
Employee Benefits	11.253	10.970
Professional Fees	4.859	5.401
Pharmaceuticals	6.940	5.416
All Other	24.950	25.527
Total	100.000	100.000

Table 7 lists the cost categories, weights, and proxies for the FY 1997-based excluded hospital market basket. For comparison, the FY 1992-based cost category weights are included. The proxies are the same as those used in the FY 1997-based acute care hospital inpatient prospective payment system market basket.

TABLE 7.—FY 1992-BASED AND FY 1997-BASED EXCLUDED HOSPITAL OPERATING COST CATEGORIES, WEIGHTS AND PRICE PROXIES

Expense categories	Rebased FY 1997-based excluded hospital market basket weights	FY 1992-based excluded hospital market weights	FY 1997-based price proxy
1. Compensation	63.251	63.721	
A. Wages and Salaries	51.998	52.152	ECI-Wages and Salaries, Civilian Hospital Workers
B. Employee Benefits	11.253	11.569	ECI-Benefits, Civilian Hospital Workers
2. Professional Fees	4.859	2.098	ECI-Compensation for Professional, Specialty & Technical
3. Utilities	1.296	1.675	
A. Fuel, Oil, and Gasoline	0.272	0.401	PPI Commercial Natural Gas
B. Electricity	0.798	1.007	PPI Commercial Electric Power
C. Water and Sewerage	0.226	0.267	CPI–U Water & Sewerage Maintenance
4. Professional Liability Insurance	0.805	1.081	CMS Professional Liability Insurance Premiums Index
5. All Other	29.790	31.425	
A. All Other Products	19.680	24.227	
(1.) Pharmaceuticals	6.940	3.070	PPI Ethical (Prescription) Drugs
(2.) Direct Purchase Food	1.233	2.370	PPI Processed Foods and Feeds
(3.) Contract Service Food	1.146	1.098	CPI–U Food Away From Home
(4.) Chemicals	2.343	3.754	PPI Industrial Chemicals
(5.) Blood and Blood Products	0.821	N/A	PPI Blood and Blood Derivatives, Human Use
(6.) Medical Instruments	1.972	3.154	PPI Medical Instruments & Equipment
(7.) Photographic Supplies	0.184	0.400	PPI Photographic Supplies
(8.) Rubber and Plastics	1.501	4.865	PPI Rubber & Plastic Products
(9.) Paper Products	1.219	2.182	PPI Converted Paper & Paperboard Products
(10.) Apparel	0.525	0.890	PPI Apparel
(11.) Machinery and Equipment	0.936	0.212	PPI Machinery & Equipment
(12.) Miscellaneous Products	0.860	2.232	PPI Finished Goods less Food and Energy
B. All Other Services	10.110	7.198	
(1.) Telephone Services	0.382	0.631	CPI–U Telephone Services
(2.) Postage	0.771	0.295	CPI–U Postage
(3.) All Other: Labor Intensive	4.892	5.439	ECI-Compensation for Private Service Occupations
(4.) All Other: Non-Labor Intensive.	4.065	0.833	CPI–U All Items
Total	100.000	100.000	

Note: Due to rounding, weights may not sum to total.

Table 8 shows the historical and forecasted updates under both the FY 1997-based and the FY 1992-based excluded hospital market baskets.

TABLE 8.—FY 1992-BASED AND FY 1997-BASED EXCLUDED HOSPITAL OPERATING INDEX PERCENT CHANGE, 1995–2004

Fiscal year (FY)	Rebased FY 1997-based excluded hospital market basket	FY 1992-based excluded hospital market basket
Historical Data:		
FY 1995	2.7	3.2
FY 1996	2.4	2.5
FY 1997	1.7	2.0
FY 1998	3.0	2.7
FY 1999	2.9	2.4
FY 2000	3.3	3.6
FY 2001	4.3	4.1
Average FYs 1995–2001	2.9	2.9
Forecast:		
FY 2002	4.0	3.0
FY 2003	3.5	3.2
FY 2004	3.1	3.2
Average FYs 2002–2004	3.5	3.1

Source: Global Insights, Inc, DRI–WEFA, 2nd Qtr. 2002; @USMACRO/MODTREND @CISSIM/TLO502.SIM.

A comparison of the FY 1997-based index incorporating the new wage and benefits proxies (ECIs) and updated occupational wage proxies is included in Table 9. Like the FY 1997-based prospective payment hospital index showed, there is little difference in the index over time when different compensation proxies are used.

TABLE 9.—FY 1997-BASED EXCLUDED HOSPITAL OPERATING INDEX PERCENT CHANGE, USING DIFFERENT WAGE AND BENEFIT PROXIES, 1995–2004

Fiscal year (FY)	Rebased FY 1997-based excluded hospital market basket	
	Using ECIs for hospital wage and benefit	Using occupational wages and Benefits proxies
Historical Data:		
FY 1995	2.7	2.9
FY 1996	2.4	2.5
FY 1997	1.7	2.2
FY 1998	3.0	3.5
FY 1999	2.9	3.0
FY 2000	3.3	3.5
FY 2001	4.3	4.1
Average FYs 1995–2001	2.9	3.1
Forecast:		
FY 2002	4.0	3.4
FY 2003	3.5	3.3
FY 2004	3.1	3.3
Average FYs 2002–2004	3.5	3.3

Source: Global Insights, Inc, DRI–WEFA, 2nd Qtr. 2002; @USMACRO/MODTREND @CISSIM/TL0502.SIM

B. Capital Input Price Index

The Capital Input Price Index (CIPI) was originally detailed in the September 1, 1992 **Federal Register** (57 FR 40016). There have been subsequent discussions of the CIPI presented in the May 26, 1993 (58 FR 30448), September 1, 1993 (58 FR 46490), May 27, 1994 (59 FR 27876), September 1, 1994 (59 FR 45517), June 2, 1995 (60 FR 29229), September 1, 1995 (60 FR 45815), May 31, 1996 (61 FR 27466), and August 30, 1996 (61 FR 46196) rules in the **Federal Register**. The August 30, 1996 rule discussed the most recent revision and rebasing of the CIPI to a FY 1992 base year, which reflects the capital cost structure facing hospitals in that year.

We are revising and rebasing the CIPI to a FY 1997 base year to reflect a more recent structure of capital costs. To do this, we reviewed hospital expenditure data for the capital cost categories of depreciation, interest, and other capital expenses. As with the FY 1992-based index, we have developed two sets of weights in order to calculate the FY 1997-based CIPI. The first set of weights identifies the proportion of hospital capital expenditures attributable to each capital expenditure category, while the second is a set of relative vintage weights for depreciation and interest. The set of vintage weights is used to identify the proportion of capital expenditures within a cost category that

is attributable to each year over the useful life of capital assets in that category. A more thorough discussion of vintage weights is provided later in this section.

Both sets of weights are developed using the best data sources available. In reviewing source data, we determined that the Medicare cost reports provided accurate data for all capital expenditure cost categories. We are using the FY 1997 Medicare cost reports for acute care prospective payment system hospitals, excluding expenses from hospital-based subproviders, to determine weights for all three cost categories: Depreciation, interest, and other capital expenses. We compared the weights determined from the Medicare cost reports to other data sources for 1997, specifically the Bureau of the Census' BES and the AHA Annual Survey, and found the weights to be consistent with those data sources.

Lease expenses are not a separate cost category in the CIPI, but are distributed among the cost categories of depreciation, interest, and other, reflecting the assumption that the underlying cost structure of leases is similar to capital costs in general. We assumed 10 percent of lease expenses are overhead and assigned them to the other capital expenses cost category as overhead, as was done in previous capital market baskets. The remaining 90 percent of lease expenses were distributed to the three cost categories based on the weights of depreciation, interest, and other capital expenses not including lease expenses.

Depreciation contains two subcategories: Building and fixed equipment and movable equipment. The split between building and fixed equipment and movable equipment was determined using the Medicare cost reports. This methodology was also used to compute the FY 1992-based index.

Table 10 presents a comparison of the rebased FY 1997 capital cost weights and the FY 1992 capital cost weights.

TABLE 10.—COMPARISON OF FY 1992 AND REBASED FY 1997 COST CATEGORY WEIGHTS

Expense categories	FY 1992 weights	Rebased FY 1997 weights	Price proxy
Total	1.0000	1.0000	
Total depreciation	0.6484	0.7135	
Building and Fixed Equipment Depreciation	0.3009	0.3422	Boeckh Institutional Construction Index—vintage weighted (23 years)
Movable Equipment Depreciation	0.3475	0.3713	PPI for machinery and equipment—vintage weighted (11 years)
Total interest	0.3184	0.2346	
Government/Nonprofit Interest	0.2706	0.1994	Average yield on domestic municipal bonds (Bond Buyer 20 bonds)—vintage weighted (23 years)
For-profit Interest	0.0478	0.0352	Average yield on Moody's Aaa bonds—vintage weighted (23 years)
Other	0.0332	0.0519	CPI—Residential Rent

Because capital is acquired and paid for over time, capital expenses in any given year are determined by past and present purchases of physical and financial capital. The vintage-weighted CIPI is intended to capture the long-term consumption of capital, using vintage weights for depreciation (physical capital) and interest (financial capital). These vintage weights reflect the purchase patterns of building and fixed equipment and movable equipment over time. Because depreciation and interest expenses are determined by the amount of past and current capital purchases, we used the vintage weights to compute vintage-weighted price changes associated with depreciation and interest expense.

Vintage weights are an integral part of the CIPI. Capital costs are inherently complicated and are determined by complex capital purchasing decisions over time, based on such factors as interest rates and debt financing. Capital is depreciated over time instead of being consumed in the same period it is purchased. The CIPI accurately reflects the annual price changes associated with capital costs, and is a useful simplification of the actual capital accumulation process. By accounting for the vintage nature of capital, we are able to provide an accurate, stable annual measure of price changes. Annual nonvintage price changes for capital are unstable due to the volatility of interest rate changes. These unstable annual price changes do not reflect the actual annual price changes for Medicare capital-related costs. CMS's CIPI reflects the underlying stability of the capital acquisition process and provides hospitals with the ability to plan for changes in capital payments.

To calculate the vintage weights for depreciation and interest expenses, we used a time series of capital purchases for building and fixed equipment and movable equipment. We found no single source that provides the best time series of capital purchases by hospitals for all of the above components of capital purchases. The early Medicare cost reports did not have sufficient capital data to meet this need. While the AHA Panel Survey provided a consistent database back to 1963, it did not provide annual capital purchases. The AHA Panel Survey did provide time series of depreciation and interest expenses that could be used to infer capital purchases over time. Although the AHA Panel Survey was discontinued after September 1997, we were able to use all of the available historical data from this survey since our base year is FY 1997.

In order to estimate capital purchases from AHA data for depreciation and interest expenses, the expected life for each cost category (building and fixed equipment, movable equipment, debt instruments) is needed. The expected life is used in the calculation of vintage weights. We used FY 1997 Medicare cost reports to determine the expected life of building and fixed equipment and movable equipment. The expected life of any piece of equipment can be determined by dividing the value of the fixed asset (excluding fully-depreciated assets) by its current year depreciation amount. This calculation yields the estimated useful life of an asset if depreciation were to continue at current year levels, assuming straight-line depreciation. From the FY 1997 cost reports, we determined the expected life of building and fixed equipment to be 23 years, and the expected life of movable equipment to be 11 years. By comparison, the FY 1992-based index showed that the expected life for

building and fixed equipment was 22 years, while that for movable equipment was 10 years. Our analysis of data for FYs 1996, 1998, and 1999 indicates very little change in these measures over time.

We used the fixed and movable weights derived from the FY 1997 Medicare cost reports to separate the AHA Panel Survey depreciation expenses into annual amounts of building and fixed equipment depreciation and movable equipment depreciation. By multiplying the annual depreciation amounts by the expected life calculations from the FY 1997 Medicare cost reports, we determined year-end asset costs for building and fixed equipment and movable equipment. We subtracted the previous year asset costs from the current year asset costs and estimated annual purchases of building and fixed equipment and movable equipment back to 1963. From this capital purchase time series, we were able to calculate the vintage weights for building and fixed equipment, movable equipment, and debt instruments. Each of these sets of vintage weights is explained in detail below.

For building and fixed equipment vintage weights, we used the real annual capital purchase amounts for building and fixed equipment derived from the AHA Panel Survey. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of the effect of price inflation. This real annual purchase amount for building and fixed equipment was produced by deflating the nominal annual purchase amount by the building and fixed equipment price proxy, the Boeckh institutional construction index. Because building and fixed equipment has an expected life of 23 years, the vintage weights for building and fixed equipment are deemed to represent the average purchase pattern of building and fixed equipment over 23-year periods.

Vintage weights for each 23-year period are calculated by dividing the real building and fixed capital purchase amount in any given year by the total amount of purchases in the 23-year period. This calculation is done for each year in the 23-year period, and for each of the twelve 23-year periods from 1963 to 1997. The average of the twelve 23-year periods is used to determine the 1997 average building and fixed equipment vintage weights.

For movable equipment vintage weights, we used the real annual capital purchase amounts for movable equipment derived from the AHA Panel Survey. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of price inflation. This real annual purchase amount for movable equipment was calculated by deflating the nominal annual purchase amount by the movable equipment price proxy, the PPI for machinery and equipment. Because movable equipment has an expected life of 11 years, the vintage weights for movable equipment are deemed to represent the average purchase pattern of movable equipment over 11-year periods.

Vintage weights for each 11-year period are calculated by dividing the real movable capital purchase amount for any given year by the total amount of purchases in the 11-year period. This calculation is done for each year in the 11-year period, and for each of the twenty-four 11-year periods from 1963 to 1997. The average of the twenty-four 11-year periods is used to determine the FY 1997 average movable equipment vintage weights.

For interest vintage weights, we used the nominal annual capital purchase amounts for total equipment (building and fixed, and movable) derived from the AHA Panel Survey. Nominal annual purchase amounts were used to capture the value of the debt instrument. Because debt instruments have an expected life of 23 years, the vintage weights for interest are deemed to represent the average purchase pattern of total equipment over 23-year periods.

Vintage weights for each 23-year period are calculated by dividing the nominal total capital purchase amount for any given year by the total amount of purchases in the 23-year period. This calculation is done for each year in the 23-year period and for each of the twelve 23-year periods from 1963 to 1997. The average of the twelve 23-year periods is used to determine the FY 1997 average interest vintage weights. The vintage weights for the FY 1992 CIPI and the FY 1997 CIPI are presented in Table 11.

TABLE 11.—1992-BASED AND 1997-BASED VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES

Year (From farthest to most recent)	Building and fixed equipment		Movable equipment		Interest	
	FY 1992 22 years	FY 1997 23 years	FY 1992 10 years	FY 1997 11 years	FY 1992 22 years	FY 1997 23 years
1	0.019	0.018	0.069	0.063	0.007	0.007
2	0.020	0.021	0.075	0.068	0.008	0.009
3	0.023	0.023	0.083	0.074	0.010	0.011
4	0.026	0.025	0.091	0.080	0.012	0.012
5	0.028	0.026	0.097	0.085	0.014	0.014
6	0.030	0.028	0.103	0.091	0.016	0.016
7	0.031	0.030	0.109	0.096	0.018	0.019
8	0.032	0.032	0.115	0.101	0.021	0.022
9	0.036	0.035	0.124	0.108	0.024	0.026
10	0.039	0.039	0.133	0.114	0.029	0.030
11	0.043	0.042	—	0.119	0.035	0.035
12	0.047	0.044	—	—	0.041	0.039
13	0.050	0.047	—	—	0.047	0.045
14	0.052	0.049	—	—	0.052	0.049
15	0.055	0.051	—	—	0.059	0.053
16	0.059	0.053	—	—	0.067	0.059
17	0.062	0.057	—	—	0.074	0.065
18	0.065	0.060	—	—	0.081	0.072
19	0.067	0.062	—	—	0.088	0.077
20	0.069	0.063	—	—	0.093	0.081
21	0.072	0.065	—	—	0.099	0.085
22	0.073	0.064	—	—	0.103	0.087

TABLE 11.—1992-BASED AND 1997-BASED VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES—Continued

Year (From farthest to most recent)	Building and fixed equipment		Movable equipment		Interest	
	FY 1992 22 years	FY 1997 23 years	FY 1992 10 years	FY 1997 11 years	FY 1992 22 years	FY 1997 23 years
23	.....	0.065	—	.....	—	0.090
Total	1.000	1.000	1.000	1.000	1.000	1.000

After the capital cost category weights were computed, it was necessary to select appropriate price proxies to reflect the rate of increase for each expenditure category. Our price proxies for the FY 1997-based CIPI are the same as those for the FY 1992-based CIPI. We still believe these are the most appropriate proxies for hospital capital costs that meet our selection criteria of relevance, timeliness, availability, and reliability. We ran the FY 1997-based index using the Moody's Aaa bonds average yield and using the Moody's Baa bonds average yield as proxy for the for-profit interest cost category. There was no difference in the two sets of index percent changes either historically or forecasted. A more detailed explanation of our rationale for selecting the price proxies is in the August 30, 1996 final rule (61 FR 46196). The proxies are presented in Table 10.

Global Insights, Inc., DRIWEFA forecasts a 0.7 percent increase in the rebased FY 1997 CIPI for FY 2003, as shown in Table 12.

TABLE 12.—FY 1992 AND FY 1997-BASED CAPITAL INPUT PRICE INDEX, PERCENT CHANGE, 1995–2004

Federal fiscal year	CIPI, FY 1992-based	CIPI, FY 1997-based
1995	1.2	1.5
1996	1.0	1.3
1997	0.9	1.2
1998	0.7	0.9
1999	0.7	0.9
2000	0.9	1.1
2001	0.6	0.9
Average: FYs 1995–2001	0.9	1.1
Forecast:		
2002	0.6	0.8
2003	0.5	0.7
2004	0.6	0.8

TABLE 12.—FY 1992 AND FY 1997-BASED CAPITAL INPUT PRICE INDEX, PERCENT CHANGE, 1995–2004—Continued

Federal fiscal year	CIPI, FY 1992-based	CIPI, FY 1997-based
Average: FYs 2002–2004	0.6	0.8

Source: Global Insights, Inc, DRI–WEFA, 2nd[t] Qtr. 2002; @USMACRO/MODTREND @CISSIM/TL0502.SIM.

This 0.7 percent increase is the result of a 1.3 percent increase in projected vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.0 percent increase in other capital expense prices, partially offset by a 2.3 percent decrease in vintage-weighted interest rates in FY 2003, as indicated in Table 13.

TABLE 13.—CMS CAPITAL INPUT PRICE INDEX PERCENT CHANGES, TOTAL AND COMPONENTS, FISCAL YEARS 1995–2005

Fiscal Year	Total	Total depreciation	Depreciation, building and fixed equipment	Depreciation, movable equipment	Interest	Other
Weights FY 1997	1.000	0.7135	0.3422	0.3713	0.2346	0.0519
Vintage-Weighted Price Changes						
1995	1.5	2.7	4.0	1.6	−1.8	2.5
1996	1.3	2.5	3.8	1.4	−2.3	2.6
1997	1.2	2.3	3.6	1.2	−2.4	2.8
1998	0.9	2.1	3.3	0.9	−3.0	3.2
1999	0.9	1.9	3.2	0.7	−2.8	3.2
2000	1.1	1.7	3.1	0.4	−1.6	3.4
2001	0.9	1.5	2.9	0.1	−2.2	4.3
Forecast						
2002	0.8	1.4	2.8	0.0	−2.2	4.3
2003	0.7	1.3	2.7	−0.1	−2.3	3.0
2004	0.8	1.3	2.6	−0.1	−2.0	2.8
2005	0.7	1.3	2.4	−0.1	−2.1	2.8

Source: Global Insights, Inc, DRI–WEFA, 2nd Qtr. 2002; @USMACRO/MODTREND @CISSIM/TL0502.SIM.

Rebasing the CIPI from FY 1992 to FY 1997 increased the percentage change in the FY 2003 forecast by 0.2 percentage points, from 0.5 to 0.7 as shown in Table 12. The difference is caused mostly by changes in cost category weights, particularly the smaller weight for interest and larger weight for depreciation. Because the interest component has a negative price change associated with it for FY 2003, the smaller share it accounts for in the FY 1997-based index means it has less of an impact than in the FY 1992-based index. The changes in the expected life and

vintage weights have only a minor impact on the overall percent change in the index. We did not receive any public comments on the rebasing and revising of the capital input price index.

V. Other Decisions and Changes to the Prospective Payment System for Inpatient Operating Costs and Graduate Medical Education Costs

A. Transfer Payment Policy

1. Expanding the Postacute Care Transfer Policy to Additional DRGs (§ 412.4)

Existing regulations at § 412.4(a) define discharges under the acute care hospital inpatient prospective payment system as situations in which a patient is formally released from an acute care hospital or dies in the hospital. Section 412.4(b) defines transfers from one acute care hospital to another, and § 412.4(c) defines transfers to certain postacute care providers. Our policy provides that, in transfer situations, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

Under section 1886(d)(5)(J) of the Act, which was added by section 4407 of Public Law 105–33, a ''qualified discharge'' from one of 10 DRGs selected by the Secretary, to a postacute care provider is treated as a transfer case beginning with discharges on or after October 1, 1998. This section requires the Secretary to define and pay as transfers all cases assigned to one of 10 DRGs selected by the Secretary, if the individuals are discharged to one of the following postacute care settings:

- A hospital or hospital unit that is not a subsection 1886(d) hospital. (Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term ''subsection (d) hospital'' as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals.)
- A skilled nursing facility (as defined at section 1819(a) of the Act).
- Home health services provided by a home health agency, if the services relate to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary).

In the July 31, 1998 final rule (63 FR 40975 through 40976), we specified the appropriate time period during which we would consider a discharge to postacute home health services to constitute a transfer as within 3 days after the date of discharge. Also, in the July 31, 1998 final rule, we did not include in the definition of postacute care transfer cases patients transferred to a swing-bed for skilled nursing care (63 FR 40977).

The Conference Agreement that accompanied Public Law 105–33 noted that ''(t)he Conferees are concerned that Medicare may in some cases be overpaying hospitals for patients who are transferred to a postacute care setting after a very short acute care hospital stay. The conferees believe that Medicare's payment system should continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust PPS [prospective payment system] payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting.'' (H.R. Report No. 105–217, 105th Cong., 1st Sess., 740 (1997).)

In the July 31, 1998 final rule (63 FR 40975), we implemented section 1886(d)(5)(J) of the Act, which directed the Secretary to select 10 DRGs based upon a high volume of discharges to postacute care and a disproportionate use of postacute care services. As discussed in the July 31, 1998 final rule, these 10 DRGs were selected in 1998 based on the MedPAR data from FY 1996. Using that information, we identified and selected the first 20 DRGs that had the largest proportion of discharges to postacute care (and at least 14,000 such transfer cases). In order to select 10 DRGs from the 20 DRGs on our list, we considered the volume and percentage of discharges to postacute care that occurred before the mean length of stay and whether the discharges occurring early in the stay were more likely to receive postacute care. We identified the following DRGs to be subject to the special 10 DRG transfer rule:

- DRG 14 (Specific Cerebrovascular Disorders Except Transient Ischemic Attack);
- DRG 113 (Amputation for Circulatory System Disorders Except Upper Limb and Toe);
- DRG 209 (Major Joint Limb Reattachment Procedures of Lower Extremity);
- DRG 210 (Hip and Femur Procedures Except Major Joint Procedures Age >17 with CC);
- DRG 211 (Hip and Femur Procedures Except Major Joint Procedures Age >17 without CC);
- DRG 236 (Fractures of Hip and Pelvis);
- DRG 263 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC);
- DRG 264 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC);
- DRG 429 (Organic Disturbances and Mental Retardation); and
- DRG 483 (Tracheostomy Except for Face, Mouth and Neck Diagnoses).

Similar to our existing policy for transfers between two acute care hospitals, the transferring hospital in a postacute care transfer for 7 of the 10 DRGs receives twice the per diem rate the first day and the per diem rate for each following day of the stay prior to the transfer, up to the full DRG payment. However, 3 of the 10 DRGs exhibit a disproportionate share of costs very early in the hospital stay in postacute care transfer situations. For these 3 DRGs, hospitals receive 50 percent of the full DRG payment plus the per diem for the first day of the stay and 50 percent of the per diem for the remaining days of the stay, up to the full DRG payment. This is consistent with section 1886(d)(5)(J)(i) of the Act, which recognizes that in some cases ''a substantial portion of the costs of care are incurred in the early days of the inpatient stay.''

The statute provides that, after FY 2000, the Secretary is authorized to expand this policy to additional DRGs. In July 1999, the previous Administration committed to not expanding the number of DRGs included in the policy until FY 2003. Therefore, CMS did not propose any change to the postacute care settings or the 10 DRGs in FY 2001 or FY 2002.

Under contract with CMS (Contract No. 500–95–0006), Health Economics Research, Inc. (HER) conducted an analysis of the impact on hospitals and hospital payments of the current postacute care transfer provision. We included in the August 1, 2000 final rule (65 FR 47079) a summary of that analysis. Among other issues, the analysis sought to evaluate the reasonableness of expanding the transfer payment policy beyond the current 10 selected DRGs.

The analysis supported the initial 10 DRGs selected as being consistent with the nature of the Congressional mandate. According to HER, ''[t]he top 10 DRGs chosen initially by HCFA exhibit very large PAC [postacute care] levels and PAC discharge rates (except for DRG 264, Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC, which was paired with DRG 263). All 10 appear to be excellent

choices based on the other criteria as well. Most have fairly high short-stay PAC rates (except possibly for Strokes, DRG 14, and Mental Retardation, DRG 429).''

The HER report discussed the issues related to potential expansion of the postacute care transfer policy to all DRGs. In favor of this expansion, HER pointed to the following benefits:

- A simple, uniform, formula-driven policy;
- The same policy rationale exists for all DRGs;
- DRGs with little utilization of short-stay postacute care would not be harmed by the policy;
- Less confusion in discharge destination coding; and
- Eliminate disparities between hospitals that happen to be disproportionately treating the current 10 DRGs and hospitals with an aggressive, short-stay, postacute care transfer policy for other DRGs.

The complete HER report may be obtained at: *http://www.cms.hhs.gov/medicare/ippsmain.asp.*

In the May 9, 2002 proposed rule, we stated that, consistent with HER's findings, we believed expanding the postacute care transfer policy to all DRGs might be the most equitable approach, since a policy that is limited to certain DRGs may result in disparate payment treatment across hospitals, depending on the types of cases treated. For example, a hospital specializing in some of the types of cases included in the current 10 DRG transfer policy would receive reduced payments for those cases transferred for postacute care after a brief acute inpatient stay, while a hospital specializing in cases not included in the current 10 DRGs could be just as aggressive in transferring its patients for postacute care, but it would receive full payment for those cases.

Another aspect of the issue is that some hospitals have fewer postacute care options available for their patients. In its June 2001 Report to Congress: Medicare in Rural America, MedPAC wrote: ''[a] shortage of ambulatory and post-acute care resources may prevent rural hospitals from discharging patients as early in the episode of care as urban hospitals would'' (page 68). MedPAC went on to note that the decline in length of stay for urban hospitals since 1989 was greater for hospitals than for rural hospitals (34 percent compared with 25 percent through 1999), presumably due to earlier discharges to postacute care settings. Although the MedPAC report contemplated returning money saved by expanding the policy to the base payment rate, thereby increasing payments for nontransfer cases, currently section 1886(d)(5)(I)(ii) of the Act provides that any expansion to the postacute care transfer policy would not be budget neutral. (Budget neutrality refers to adjusting the base payment rates to ensure total aggregate payments are the same after implementing a policy change as they were prior to the change.) Nevertheless, over the long run, reducing Medicare Trust Fund expenditures for patients who are transferred to a postacute care setting after a very short acute care hospital stay would improve the program's overall financial stability.

As noted in the proposed rule, we believe that the current policy may create payment inequities among patients and among hospitals. By expanding the postacute care transfer policy, we would expect to reduce or eliminate these possible inequities. Therefore, in the May 9, 2002 proposed rule, we announced two options that we might use to expand the postacute care transfer provision and solicited comments and additional methodologies from commenters. The first method we proposed was to expand the postacute care transfer provision to all DRGs. The second proposal was to expand the provision to an additional 13 DRGs (We selected 10 DRGs using the same methodology we used in the July 31, 1998 final rule. Three of these 10 additional DRGs were paired, making the total 13.). However, expanding the postacute care transfer policy in this limited manner would retain many of the potential inequities of the current system.

As discussed further in the specific comments and responses that follow, we are not expanding the discharge to postacute care provision to additional DRGs for FY 2003. We believe the commenters have raised many issues regarding the impact of expanding this policy that we need to consider carefully before proceeding. In particular, due to the limited time between the close of the comment period and the required publication date of August 1, we were unable to completely analyze and respond to all of the points that were raised. However, we will continue to conduct research to assess whether further expansion of this policy may be warranted for FY 2004 or subsequent years and, if so, how to design any such refinements.

Comment: Many commenters argued that, in a system based on averages, expansion of the postacute care transfer policy negatively influences, and in fact penalizes, hospitals for efficient care. They claimed that this policy indiscriminately penalizes hospitals for efficient treatment and for ensuring that patients receive the right care at the right time in the right place. They believed that the postacute care transfer provision creates a perverse incentive for hospitals to keep patients longer.

Commenters also stated their concern that the expansion of the transfer provision violates the fundamental principle of the Medicare DRG payment system. The system is based on payments that will, on average, be adequate. These commenters argued that expansion of the transfer policy would give the system a per-diem focus and would mean that hospitals would be paid less for shorter than average lengths of stay, although they would not be paid more for the cases that are longer than average (except for outlier cases). One commenter suggested that if we expand the transfer rule, we should adopt a policy to pay more for long-stay cases.

Response: The Conference Agreement accompanying Public Law 105–33 states that ''Medicare's payment system should continue to provide hospitals with strong incentives to treat patients in the most effective and efficient manner, while at the same time, adjust [prospective payment system] payments in a manner that accounts for reduced hospital lengths of stay because of a discharge to another setting.'' The current postacute care transfer policy adjusts payments to hospitals to reflect the reduced length of stay arising from the shift of patient care from the acute care setting to the postacute care setting. In addition, because Medicare also often pays for the postacute care portion of beneficiaries' care, the transfer policy appropriately adjusts hospitals' payments to avoid duplicate payments for the care provided during a patient's episode of care.

However, we are not expanding the postacute care transfer policy in this final rule because we are not able to completely respond to all of the points raised by commenters prior to publication of the final rule. Specifically, we intend to undertake a more comprehensive analysis of the impact on the averaging aspects of the prospective payment system if this policy were to be expanded. We agree with the commenters that the transfer policy should not hamper the provision of effective patient care, and any future expansion will consider both the need to reduce payments to reflect cost-shifting due to reductions in length of stay attributable to early postacute care transfers and the need to ensure that payments, on average, remain adequate to ensure effective patient care.

Comment: Commenters believed that the proposal to expand the postacute care transfer policy would place an additional administrative burden on hospitals and would expand the liability of hospitals for decisions that are not in their control, particularly after the patient has gone home. In cases where an acute care hospital is unaware that a patient has been sent to a postacute care facility or is receiving home health care, the commenters argued that it should not be the burden of the hospital to obtain that information.

Response: As stated previously, we are not expanding the postacute care transfer policy at this time. In response to the point raised by the commenter, with respect to our current policy, in those cases where the hospital discharges a beneficiary to home and the beneficiary subsequently receives postacute care, without the hospital's knowledge, the incorrect discharge code will not be considered fraudulent. However, if the hospital has knowledge of the beneficiary receiving postacute care after discharge, the hospital is responsible for submitting the claim as a transfer or submitting an adjustment bill.

Comment: Some commenters noted that, although the statute clearly states that the Secretary is authorized to expand the postacute care transfer policy to additional DRGs, the Secretary is not required to do so. These commenters pointed to the policy decisions made in FY 2001 and FY 2002 not to expand the policy and encouraged CMS to make the same policy decision for this and all subsequent years, calling the proposed expansion unjustified and unreasonable.

Several commenters argued that, although the Secretary does have authority to expand the postacute care transfer provision, the Secretary was not given the authority to expand the provision to all DRGs. Section 1886(d)(5)(J)(iv) of the Act provides that the Secretary may extend the policy to additional DRGs with high volumes of discharges to postacute care settings. Commenters noted that not all DRGs meet this criteria.

Response: We agree that we are not required by section 1886(d)(5)(J)(iv) of the Act to expand the transfer provision beyond the 10 DRGs currently covered under the policy. However, the statute clearly indicates that the policy may be expanded further, as appropriate. Whether the policy should be expanded to all DRGs or a few will be considered in future analysis.

Comment: Several commenters believed that the impact of the expansion of the postacute care transfer needs to be considered more thoroughly and noted that the impact of such an expansion was not included in the proposed rule impact tables. These commenters were concerned that the overall effect of implementing either of the two proposed expansions would result in an overall decrease in per case payments in FY 2003. Commenters believed this expansion would disproportionately harm teaching hospitals that treat the most costly and complex cases within each DRG. They further charged that this policy would interfere with good clinical decisionmaking.

Response: We did not analyze the postacute care transfer policy in the impact tables in the proposed rule because we did not propose a specific policy expansion. We did include overall savings estimates attributable to the provision in the preamble discussion. The full impact of any proposed expansion of this policy, including the impacts on specific categories of hospitals, would be considered fully before proceeding to expand the policy in the future.

Comment: Many commenters strongly opposed the proposal to expand the postacute care transfer policy to all DRGs. Several commenters suggested that we repeal the original 10 DRG postacute care transfer policy provision, on the grounds that, through experience, hospitals have learned to operate more efficiently and seek best practices in patient care management. Therefore, the prospective payment system has met its objectives and lengths of stay have been reduced. In addition, the commenters noted that the lower length of stay achieved is better for patients due to lower risk of acquiring a nosocomial infection and better recovery rates at home. Therefore, the commenters argued, hospitals that have shortened the length of stay across all DRGs should not be punished by a reduction in payment amounts to per diem rates. As such, the commenters argued that premature discharges should be identified through the Quality Improvement Organization review process and not by the prospective payment system.

Response: We agree that shorter lengths of stay are better for patients in general and that more efficient hospitals should not be penalized for greater than average efficiency. In the July 31, 1998 final rule implementing the policy for the current 10 DRGs, we included analysis showing that, across virtually all lengths of stay for each of the 10 DRGs, Medicare paid in excess of costs even after the implementation of this provision. We also note that we do not believe the intent of this policy was to require a change in physician clinical decisionmaking, nor in the manner in which physicians and hospitals practice medicine. Rather, it simply addresses the appropriate level of payments once those decisions have been made, so the intent of the policy was to avoid overpayments. We agree with the commenter that an appropriate mechanism to identify premature discharges is the quality review process. As we have noted above, we will consider fully all of the financial implications on hospitals before proceeding to expand the policy in the future.

Comment: Some commenters stated that there is no longer any justification to expand the postacute care policy, particularly to all DRGs. Commenters argued that expansion is unjustified because at the time the original policy was implemented, data showed that lengths of stay were dropping and that use of postacute care was increasing. The commenters indicated that, since that time, inpatient length of stay has stabilized and Medicare spending on postacute care has slowed. In addition, any incentive hospitals may have had to discharge patients early to a postacute care facility has been removed now that Medicare also pays these facilities under prospective payment systems.

In addition, commenters stated that neither CMS nor its contractor, HER, has provided data to support the assumption that hospitals are benefiting financially from short-stay postacute care transfer cases. In fact, commenters noted that the HER report included one table that suggests the opposite is true. As described by the commenters, Table 4–8 in the HER report shows the average cost of short-stay cases in the 10 DRGs currently subject to the payment reduction. As shown by this table, short-stay postacute transfer cases are 7.4 percent more costly than short-stay nonpostacute care transfer cases. As a result, the commenters asserted that postacute care transfer cases are significantly less profitable than the non-postacute care transfer cases.

Response: While it is true that postacute care providers such as skilled nursing facilities, home health agencies, and rehabilitation hospitals are now paid under prospective payment systems rather than cost-based payment systems, the acute hospital still has an incentive to discharge patients as soon as possible. The impact of expanding prospective payments to other settings is that it changes the incentives for those providers in terms of their willingness to continue to accept patients needing a more acute level of

care, because sicker patients are more likely to have above average costs. There is no impact on the incentives of acute care hospitals.

We point out that the analysis prepared by HER was undertaken as an evaluation of the original policy, conducted in 2000 based on partial FY 1999 data. With respect to HER's finding that patients transferred for postacute care are more expensive than cases discharged home, one would expect cases receiving followup care to be sicker and require more resources. In fact, the postacute care transfer policy was implemented out of concern that these patients were being transferred out of the acute care setting much earlier in the course of their treatment than had previously been the case, and that some of the acute care portion of the patients' hospitalization was being provided by the postacute care facility. Because the acute care hospital was receiving the full DRG payment and the postacute care facility was receiving higher cost-based reimbursement, the Medicare program was paying, in essence, two facilities for the acute care of the patient.

Comment: Commenters noted that in the proposed rule CMS quoted five points from the HER report that supported an expansion of the provision, but did not include the section of the HER report that lists the arguments against expansion. The commenters included this list of HER's arguments against expansion:

- Expansion to all DRGs would require multiple per-diem payment policies. The current ten DRGs require two distinct payment methodologies to ensure equitable reimbursement. A policy covering all DRGs might require many more methodologies.
- The policy would be irrelevant for many DRGs. Many DRGs have few or no cases that are discharged to postacute care.
- Expansion to all DRGs would have relatively high costs compared to the benefits. There is little benefit to extending the policy to the many DRGs with low postacute care volume. The cost of requiring that fiscal intermediaries implement and audit compliance with the policy for these DRGs would dilute the overall benefit to the program.
- It would be difficult to identify unrelated postacute care cases prior to admission. If a patient is under postacute care before admission and then returns to that care after an unrelated admission, the transfer policy does not apply. With many more DRGs, CMS and hospitals would have more work sorting out the unrelated admissions.
- Many DRGs are ''inhomogeneous.'' HER cautioned that payment under the postacute care transfer policy would be inequitable for ''inhomogeneous DRGs'' that contain two or more distinct types of cases with disparate lengths of stay.

Response: The negative points raised above were included in our report of HER's analysis in the August 1, 2000 final rule (65 FR 47081). We note that in the final rule we also referred readers to where they could obtain a copy of the complete report.

Comment: Commenters analyzed the 13 DRGs identified in the proposed rule for possible partial expansion of the postacute care transfer policy using information derived from the FY 2000 MedPAR data. The commenters reported that many of the DRGs are inhomogeneous, including a wide variety of cases, some of which may be susceptible to early transfer and some of which may not.

Response: We are not adopting either of the methodologies for expanding the postacute care transfer policy at this time. However, if in the future we should consider expanding the policy, we will consider the effect of inhomogeneity in any DRGs we select.

Comment: Some commenters believed that the current system is inequitable. However, they argued that targeting 13 additional DRGs would only worsen the problem, and extending the policy to all DRGs is not an acceptable response. Commenters urged us to work to have the policy repealed altogether or at least to revise the policy to make it more equitable. For example, commenters noted that DRG 483 (Tracheostomy except for face, mouth and neck diagnoses), which is included under the current policy, has an average length of stay of 35 days. Commenters noted that the variation around the average is quite high, and that patients requiring this procedure and level of care almost always require postacute care. Therefore, commenters contended, because the variation around the average is so large, and the per diem cost for this DRG is well above average, the postacute care transfer policy has a very significant impact on payment that is unrelated to the use of postacute care services. These commenters urged us to reconsider the current policy because they believed that the logic of applying the standard per diem methodology to this DRG is flawed. They urged us either toreplace this DRG with another one on its high-volume postacute care transfer list or change the payment method to one that addressed the length of stay volatility.

Response: We believe the current policy remains an appropriate response to reductions in length of stay resulting from shifting care out of the acute hospital setting. However, as noted above, we do have concerns about limiting it to 10 specific DRGs. We will continue to closely monitor the data to assess whether future expansions or refinements are needed. With respect to the inclusion of DRG 483 in the current 10 DRGs covered by the postacute care transfer policy, in the July 31, 1998 final rule we responded to a similar comment (63 FR 40981). Our analysis showed this DRG was appropriate to include under the policy. Over 45 percent of discharges from this DRG were to postacute care, and it was ranked ninth in terms of volume of cases receiving postacute care. These factors qualify it for inclusion in the postacute care transfer policy under section 1886(d)(5)(J) of the Act.

Comment: One commenter contended that expanding the postacute care transfer provision would distort the meaning of a transfer case. According to the commenter, a transfer is a case that has been admitted to one hospital and is stabilized there, but which is then sent to another acute care hospital for treatment that the first hospital was not equipped to provide. The commenter further explained that patients discharged to postacute care, in contrast, have completed the acute care phase of their treatment and need postacute care either to assist their convalescence or to manage a chronic illness. The commenter contended that these are very different concepts.

Response: Under the acute inpatient prospective payment system, payments to the transferring hospital are reduced to reflect the fact that the patient is transferred prior to receiving the full course of treatment from the acute hospital. When Congress established the postacute care transfer policy, it did so in recognition of the fact that hospitals were transferring patients who still had acute symptoms into the postacute care setting for the remainder of their care. Therefore, the principle that the transferring hospital did not provide the full course of treatment is consistent under both the preexisting policy and the postacute care transfer policy.

Comment: One commenter claimed that the special payment formula for a transfer from DRG 209, 210 and 211 often results in less payment than the flat per diem method. The commenters provided an example assuming that a DRG with a payment of $10,000 and an average length of stay of 5 days received a per diem rate of $2,000. For a transfer case with a stay of 4 days under the

standard per diem transfer payment, the payment rate would be $10,000 ($4,000 for the first day and $2,000 for each of the next 3 days). The commenter argued that, under the special transfer payment policy, the payment rate would be only $8,000 ($5,000 for the first day and $1,000 for each of the next 3 days). The commenter recommended that we increase the percentage of the per diem paid on days after the first day to 75 percent of the per diem under the special payment method.

Response: Under § 412.4(f)(2), payment for a postacute care transfer case from DRGs 209, 210, or 211 is equal to 50 percent of the appropriate prospective payment rate for the first day of the stay, and 50 percent of the amount the hospital would receive under the standard transfer payment methodology. Thus, the example provided by the commenter is not correct. The payment would be the full $10,000 if the patient was transferred on the fourth day. Rather than receiving $5,000 for the first day, the hospital in the example would receive $7,000 (50 percent of the full DRG payment equals $5,000, plus 50 percent of the standard transfer payment equals $2,000, because the standard transfer payment is double the per diem for the first day of a transfer stay). The hospital would receive $1,000 for each of the next 3 days, resulting in total payments under this special transfer payment rule equal to $10,000 on day 4.

This example also demonstrates that, if the patient stay is one day shorter than average, the hospital receives the full DRG rate. Using both postacute care transfer payment methodologies, the hospital would receive the full DRG amount if the patient stay is one day shorter than the national average.

Comment: One commenter suggested that we determine if the administrative resources we are using to recalculate a hospital's payment under this policy are actually saving the Medicare program money or if a greater amount of administrative resources are spent to recover the payment differential for the transferred beneficiary. The commenter stated that we should not expand a ''cost-savings'' policy that fails to result in true savings.

Response: Currently, the transfer payment calculation is made at the time a claim is processed based on the discharge status code assigned by the hospital to the patient at the time of discharge. Therefore, there is no recalculation, and thus the administrative costs associated with this policy are marginal, as long as hospitals appropriately code the patient's discharge status.

Comment: Another commenter recommended that the postacute care transfer issue be addressed from a total system perspective, centered on meeting the patients' needs and include referral dynamics from the new postacute care prospective payment systems. The commenter also suggested that there should be an analysis of the medical versus payment dynamics of the 3-day prior hospitalization requirement for postacute care coverage.

One commenter suggested that we expand the postacute care transfer policy to include swing beds. The commenter pointed to the ease with which hospitals may move these swing beds from one care setting to another, suggesting that it would be easy for hospitals with swing beds to get around the existing transfer policy.

Response: We will take these suggestions into consideration as we continue to monitor the transfer policy. With respect to expanding the policy to include transfers to swing beds, we indicated in the July 31, 1998 final rule that we elected not to include swing beds under this policy because of the potential adverse impact on small rural hospitals. At this time, we are not changing this policy, although we will continue to evaluate whether it is appropriate to exclude transfers to swing beds from the postacute care transfer policy.

Comment: One commenter recommended waiting at least 3 years before expanding the transfer policy to provide for sufficient time for the entire continuum of care to reach equilibrium. In addition, the commenter indicated that when independent groups analyzed internal data on the 10 DRGs initially identified in the existing postacute care transfer policy, they found only 3 where there were significant numbers of transfers to postacute care. The commenter recommended reanalyzing the current policy to determine whether volume and disposition of the DRGs still require the policy. Some commenters stated that the perceived ''gaming'' hypothesis does not exist, meaning that hospitals are not cutting short patient care in order to make more money. Another commenter suggested that we monitor the recalibration of DRG weights, noting that if patients are being discharged too soon, these premature discharges would be reflected in frequent readmissions to the hospital, would increase the acuity of postacute care providers, and would lower the charges for acute stays. Earlier discharges will ultimately result in lower weights for associated DRGs. The commenter indicated that we could then easily monitor readmissions and acuity of postacute care treatment to target problem providers.

Response: We will examine these and other issues in future analysis of this issue. With respect to the treatment of transfers in DRG recalibration, we note that a transfer case is counted as only a fraction of a case toward DRG recalibration based on the ratio of its transfer payment to the full DRG payment for nontransfer cases. This ensures the DRG weight calculation is consistent with the payment policy for these cases.

2. Technical Correction

When we revised our regulations on payments for discharges and transfers under § 412.4 in the July 31, 1998 final rule (63 FR 41003), we inadvertently excluded discharges from one hospital area or unit to another inpatient area or unit of the hospital that is paid under the acute care hospital inpatient prospective payment system (§ 412.4(b)(2)) in the types of cases paid under the general rule for transfer cases. In the May 9, 2002 proposed rule, we proposed to correct the regulation text to reflect our policy (as reflected in prior preamble language) that transfers from one area or unit within a hospital to another are not paid as transfers (except as described under the special 10 DRG rule at § 412.4(c)). We proposed to correct this error by revising § 412.4(f)(1) to provide that only the circumstances described in paragraphs (b)(1) and (c) of § 412.4 are paid as transfers under the general transfer rule.

We did not receive any public comments on this proposal. Therefore, we are adopting the proposed revisions of the regulations text as final. This correction reflects the fact that transfers under § 412.4(b)(2) are to be paid as discharges and not transfers.

B. Sole Community Hospitals (SCHs) (§§ 412.77 and 412.92)

1. Phase-In of FY 1996 Hospital-Specific Rates

Under the acute care hospital inpatient prospective payment system, special payment protections are provided to a sole community hospital (SCH). Section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, absence of other like hospitals (as determined by the Secretary), or historical designation by the Secretary as an essential access community hospital, is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria that

a hospital must meet to be classified as an SCH are located in § 412.92.

To be classified as an SCH, a hospital either must have been designated as an SCH prior to the beginning of the hospital inpatient prospective payment system on October 1, 1983, or must be located more than 35 miles from other like hospitals, or the hospital must be located in a rural area and meet one of the following requirements:

• It is located between 25 and 35 miles from other like hospitals, and it—

—Serves at least 75 percent of all inpatients, or at least 75 percent of Medicare beneficiary inpatients, within a 35-mile radius or, if larger, within its service area; or

—Has fewer than 50 beds and would qualify on the basis of serving at least 75 percent of its area s inpatients except that some patients seek specialized care unavailable at the hospital.

• It is located between 15 and 35 miles from other like hospitals, and because of local topography or extreme weather conditions, the other like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years.

• The travel time between the hospital and the nearest like hospital is at least 45 minutes because of distance, posted speed limits, and predictable weather conditions.

Effective with hospital cost reporting periods beginning on or after April 1, 1990, section 1886(d)(5)(D)(i) of the Act, as amended by section 6003(e) of Public Law 101–239, provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period:

• The Federal rate applicable to the hospital;

• The updated hospital-specific rate based on FY 1982 costs per discharge; or

• The updated hospital-specific rate based on FY 1987 costs per discharge.

Section 405 of Public Law 106–113 added section 1886(b)(3)(I) to the Act, and section 213 of Public Law 106–554 made further amendments to that section of the Act extending to all SCHs the ability to rebase their hospital-specific rates using their FY 1996 operating costs, effective for cost reporting periods beginning on or after October 1, 2000. The provisions of section 1886(b)(3)(I) of the Act were addressed in the June 13, 2001 interim final rule with comment period (66 FR 32177) and were finalized in the August 1, 2001 final rule (66 FR 39872).

In the June 13, 2001 interim final rule, we correctly described the provisions of section 1886(b)(3)(I) of the Act, as amended, and their implementation. However, in the August 1, 2001 final rule, in summarizing the numerous legislative provisions that had affected payments to SCHs, we incorrectly described the application of the statutory provisions in the background section of the preamble on SCHs (66 FR 39872). (We wish to point out that the Addendum to the August 1, 2001 final rule accurately describes the calculation of the hospital-specific rate (66 FR 39944).) Specifically, the payment options that we described in the August 1, 2001 preamble language regarding SCHs were incorrect in that we did not include the Federal rate in the blends. Therefore, we are providing below a correct description of the provisions of section 1886(b)(3)(I) of the Act and clarifying their application in determining which payment options will yield the highest rate of payment for an SCH.

For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, the Federal rate is included in the blend, as set forth below:

• For discharges during FY 2001, 75 percent of the greater of the Federal amount or the updated FY 1982 or FY 1987 hospital-specific rates (identified in the statute as the subsection (d)(5)(D)(i) amount), plus 25 percent of the updated FY 1996 hospital-specific rate (identified in the statute as the ''rebased target amount'').

• For discharges during FY 2002, 50 percent of the greater of the Federal amount or the updated FY 1982 or FY 1987 hospital-specific rates, plus 50 percent of the updated FY 1996 hospital-specific rate.

• For discharges during FY 2003, 25 percent of the greater of the Federal amount or the updated FY 1982 or FY 1987 hospital-specific rates, plus 75 percent of the updated FY 1996 hospital-specific rate.

• For discharges during FY 2004 and subsequent fiscal years, the hospital-specific rate would be determined based on 100 percent of the updated FY 1996 hospital-specific rate.

For each cost reporting period, the fiscal intermediary determines which of the payment options will yield the highest rate of payment. Payments are automatically made at the highest rate using the best data available at the time the fiscal intermediary makes the determination. However, it may not be possible for the fiscal intermediary to determine in advance precisely which of the rates will yield the highest payment by year's end. In many instances, it is not possible to forecast the outlier payments, the amount of the disproportionate share hospital (DSH) adjustment, or the indirect medical education (IME) adjustment, all of which are applicable only to payments based on the Federal rate. The fiscal intermediary makes a final adjustment at the close of the cost reporting period to determine precisely which of the payment rates would yield the highest payment to the hospital.

If a hospital disagrees with the fiscal intermediary's determination regarding the final amount of program payment to which it is entitled, it has the right to appeal the fiscal intermediary's decision in accordance with the procedures set forth in Subpart R of Part 405, which concern provider payment determinations and appeals.

The regulation text of § 412.77 and § 412.92(d) that was revised to incorporate the provisions of section 1886(b)(3)(I) of the Act, as amended, and published in the June 13, 2001 interim final rule with comment period (66 FR 32192 through 32193) and finalized in the August 1, 2001 final rule (66 FR 39932), is accurate.

We did not receive any comments on this clarification.

2. SCH Like Hospitals

Section 1886(d)(5)(D)(iii) of the Act provides that, to qualify as an SCH, a hospital must be more than 35 road miles from another hospital. In addition, there are several other conditions under which a hospital may qualify as an SCH, including if it is the ''* * * sole source of inpatient hospital services reasonably available to individuals in a geographic area * * *'' because of factors such as the ''* * * absence of other like hospitals * * *'' We have defined a ''like hospital'' in regulations as a hospital furnishing short-term, acute care (§ 412.92(c)(2)). Like hospitals refers to hospitals paid under the acute care hospital inpatient prospective payment system.

We have become aware that, in some cases, new specialty hospitals that offer a very limited range of services have opened within the service area of an SCH and may be threatening the special status of the SCH. For example, a hospital that offers only a select type of surgery on an inpatient basis would qualify under our existing rules as an SCH ''like hospital'' if it met the hospital conditions of participation and was otherwise eligible for payment under the acute care hospital inpatient prospective payment system. Under our existing regulations, an SCH could lose its special status due to the opening of such a specialty hospital, even though there is little, if any, overlap in the types

of services offered by the SCH and the specialty hospital.

We believe that limiting eligibility for SCH status to hospitals without SCH like hospitals in their service area is a way to identify those hospitals that truly are the sole source of short-term acute-care inpatient services in the community. A limited-service, specialty hospital, by definition, would not offer an alternate source of care in the community for most inpatient services and therefore, we believe, should not be considered a ''like'' hospital with the effect of negating SCH status of a hospital that is the sole source of short-term acute care inpatient services in the community. Therefore, in the May 9, 2002 proposed rule, we proposed to amend the definition of SCH like hospitals under § 412.92(c)(2), effective with cost reporting periods beginning on or after October 1, 2002, to exclude any hospital that provides no more than a very small percent of the services furnished by the SCH. We believe the percentage of overlapping services between the SCH and the limited service facility should be sufficiently small so that we can ensure that only hospitals that truly are the sole source of short-term acute care in their community qualify for SCH status. Therefore, we proposed that this percentage be set at 3 percent.

In the May 9, 2002 proposed rule, we solicited public comments on alternate appropriate levels of service overlap, as well as on the overall proposed change to the definition of like hospitals.

In response to comments as discussed below, we are adopting inpatient days as the unit of measurement for determining whether a hospital applying for SCH status can exclude from consideration as a like hospital another hospital within its service area (rather than services, as discussed in the proposed rule). The threshold would be set so that a hospital with total inpatient days of 8 percent or less compared to an SCH (or SCH applicant) would not be considered a like hospital for purposes of SCH designation.

We believe that Medicare inpatient days are a good proxy for service overlap. However, we will assess the impact of the overall change to the definition of like hospital and the service overlap proxy on SCHs and the prospective payment system. This assessment will determine whether refinements to this policy may be necessary in future years.

Comment: Many organizations commented on this proposal. Most supported it, but to varying degrees, because there is additional information they believe they need in order to better evaluate the proposal. The commenters noted definitions are needed for terms such as ''services'', ''overlap'', and ''provided services''. They also indicated that the data source (such as hospital cost reports or actual claims experience) and the methodology for measuring the services need to be defined and requested clarification of these issues in the final rule.

For example, commenters asked how CMS will measure overlap of services between the specialty hospital and the SCH (or SCH applicant). Would there be a weighting for volume or the volume capacity of the limited service specialty hospital? Would it be 3 percent of service lines (for example, obstetrics, cancer care, or cardiac services), or discharges, or DRGs reported?

Response: We appreciate the many helpful comments we received on this proposal. We proposed a 3-percent threshold of service overlap in an attempt to strike a balance between the need to ensure that SCHs do not lose their special status due to specialty hospitals opening nearby and the need to ensure that only hospitals that are the sole source of short-term acute hospital services for their community qualify as SCHs. We were concerned not to set the threshold too high because we wanted to ensure that only hospitals that truly are the sole source of care for their community continue to qualify as SCHs. Based on the comments we received, we are adopting alternative criteria, as described below. Adoption of this alternative criteria, comparing inpatient days, renders moot many of the questions raised by the commenters discussed above.

Comment: Some commenters pointed out that specialty hospitals take away profitable services that subsidizes other critical services such as emergency room service, intensive care unit services, skilled nursing care, and home health and hospice care furnished by the hospitals that typically qualify as SCHs.

These commenters believed SCH status was instituted to allow these types of providers the ability to provide access to a full range of services for Medicare patients, and that, as a result, these SCHs need to be protected.

One commenter requested that we require a hospital, to be considered a like hospital for purposes of SCH determinations, to provide, on an ongoing basis, all of the services typically furnished by an SCH, such as 24-hour emergency service and surgery and obstetrics services.

Some commenters recommended that the services provided by a limited-service specialty hospital should be defined so that, if the hospital had the capability of providing a service such as emergency service but was not staffed for 24-hour emergency service, was staffed only to the extent of referring its emergency patients to the SCH, or provided only its specialty-related emergency service, the hospital would not be considered to be furnishing emergency services, and, as a result, the hospital would not be considered a like hospital.

Other commenters did not believe that percentages of specific DRGs or a similar calculation of limited services would be a fair and equitable method of determining SCH status, particularly when considering whether a hospital with SCH status should be permitted to retain such status.

One commenter supported the proposal to amend the definition of SCH like hospitals to exclude any hospital that offers a very limited range of services. However, the commenter did not support the percent-of-services methodology. The commenter stated that the administrative burden associated with making this determination would be too great for both providers and intermediaries.

Response: Our proposal was intended to measure the extent of overlapping services because this would seem to be a useful indicator to determine whether another hospital in the community offers a plausible alternative to the SCH for residents in the area seeking inpatient acute care. For example, the existing regulations contemplate situations where hospitals with fewer than 50 beds may become eligible for SCH status despite the location of an otherwise like hospital within 35 miles, if the community hospital would admit at least 75 percent of the area residents who become inpatients were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital (§ 412.92(a)(1)(ii)).

Section 2810.B.3.d. of the Provider Reimbursement Manual contains instructions for excluding services not offered by the SCH applicant from the determination of whether the applicant admits at least 75 percent of the area residents who become inpatients. Under this process, the hospital obtains information as to the diagnoses of and services furnished to those residents or Medicare beneficiaries who obtained care outside the SCH applicant hospital's service area during the survey period.

In connection with the policy we proposed in the May 9, 2002 proposed

rule, we contemplated using a similar process to determine whether a limited-service specialty hospital should be excluded from the definition of like hospitals. However, we recognize that this process would be labor and data intensive. As a result, we were interested in evaluating the recommendations submitted by commenters.

Comment: Several commenters suggested using Medicare inpatient days in hospital units subject to the acute care hospital inpatient prospective payment system to identify whether a limited-service specialty hospital is likely to offer many of the services also offered by the SCH. Thus, for example, a specialty hospital that only provides orthopedic surgery with a 1-day recovery period would have its service weighted to reflect the limited intensity of such services.

Commenters believe that using Medicare inpatient days would allow easy administration by both CMS and its fiscal intermediaries, because these data are readily available in hospital cost reports. They believed that by considering only inpatient days in units subject to the acute care hospital inpatient prospective payment system, the focus would be limited only to those services germane to the general acute care needs of the Medicare community. Other commenters suggested using actual gross payments for Part A services to Medicare beneficiaries as the unit of measurement for services provided.

Response: We agree with the commenters who proposed using inpatient days as the comparative statistic to determine whether a limited-service specialty hospital may be excluded from the like hospital definition. Although DRGs provide a comparison that more closely reflects service overlap, we believe that we will attain a similar outcome, with less administrative complexity, by comparing inpatient days. Accordingly, we are adopting patient days attributable to units that provide a level of care characteristic of the level of care payable under the acute care hospital inpatient prospective payment system as the unit of measurement for determining whether a hospital applying for SCH status can exclude from consideration as a like hospital another hospital within its service area. The number of inpatient days is readily available from all participating hospitals because it is already captured on the cost report.

We believe that Medicare inpatient days are a good proxy for service overlap. However, we will assess the impact of the overall change to the definition of like hospital and the service overlap proxy on SCHs and the prospective payment system. This assessment will determine whether refinements to this policy may be necessary in future years.

Comment: The commenters were in agreement that the overlapping services threshold of 3 percent was too low and would not accomplish our intent of distinguishing specialty hospitals from full-service acute care hospitals. Alternative suggestions included overlapping services thresholds of 8 percent, 10 to 15 percent, and setting the threshold after evaluating actual data. One commenter stated that adopting less than a 10-percent overlap threshold would not protect existing SCHs from losing their special status as a result of a limited-service specialty hospital opening in their community.

Commenters offered the example where a heart hospital or other niche provider may perform inpatient services that represent closer to 10 or 15 percent of the services performed by SCHs. In this situation the SCH continues to remain the sole source of the full range of acute care services in the community, including essential emergency services, and thus deserves to retain SCH status. However, if the specialty hospital is considered a like hospital, it would jeopardize the special status of the SCH.

One commenter referred to the regulations, where, to qualify for SCH status, a hospital with another like hospital within 25 to 35 miles cannot have more than 25 percent of the admissions of residents within its service area admitted to other hospitals (§ 412.92(a)(1)(i)). The commenter suggested that, where the focus is on specialty hospitals that are not like hospitals, a threshold on the order of one-third of that 25-percent threshold would seem appropriate. The commenter suggests that a specialty hospital with only 8 percent service overlap with the community hospital would not be able to service the community's acute care needs.

Response: As stated above, based on our evaluation of the public comments and the situations, of which we are aware, where an existing SCH's special status is being threatened by a nearby limited-service specialty hospital, we believe the best approach would be to revise our proposed definition of like hospital for SCH purposes to exclude any hospital where the inpatient services overlap compared to the SCH (or the SCH applicant) is less than 8 percent, as measured by inpatient days.

The inpatient services would be measured by total inpatient days as reported on the hospitals' cost report, and should include all days attributable to units that provide a level of care characteristic of the level of care payable under the acute care hospital inpatient prospective payment system. We believe setting the threshold at 8 percent would distinguish the specialty hospitals, which have very limited inpatient use and, therefore, limited inpatient days, from general, acute care hospitals typical of SCHs. Therefore, we are revising proposed § 412.92 (c)(2) to reflect this change.

To determine whether a hospital qualifies as an SCH, the fiscal intermediary would make a determination whether a nearby hospital paid under the acute care hospital inpatient prospective payment system is a like hospital by comparing the total acute inpatient days of the SCH applicant hospital with the total acute inpatient days of the nearby hospital. If the total acute inpatient days of the nearby hospital is greater than 8 percent of the total inpatient days reported by the SCH applicant hospital, the hospital is considered a like hospital for purposes of evaluating the application for SCH status. If the total acute inpatient days of the nearby hospital is 8 percent or less of the total acute inpatient days of the applicant hospital, the nearby hospital is not considered a like hospital for purposes of evaluating the application for SCH status under § 412.92.

Comment: Some commenters questioned the effective date of the proposal because they see the definition revision as a clarification of existing legislation that should be treated as such, applying to all open matters, not prospectively only.

Response: This change is a revision to our current policy for defining like hospitals. Therefore, it is being implemented prospectively, starting with cost reporting periods that begin on or after October 1, 2002.

Current regulations establish that an approved SCH classification remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved (§ 412.92(b)(3)). It will be necessary, therefore, in situations where a SCH's eligibility is contingent on a nearby hospital being excluded from the like hospital comparison under this provision, for the fiscal intermediary to reevaluate periodically whether the exclusion is still appropriate, based on the most current inpatient days data.

In the event that a new, limited-service specialty hospital opens within the service area of an existing SCH, the

fiscal intermediary will monitor the number of patient days at the two hospitals to ensure that the specialty hospital does not exceed the 8 percent threshold.

Comment: Some commenters stated that, without understanding how the test actually would be conducted, what data would be used, and why a 3 percent threshold was selected, interested parties could not provide us with thoughtful, helpful comments. Accordingly, they recommended that we not finalize our proposal at this time. Instead, we should clarify our proposal and resolicit comments. In the interim, these commenters believed that we should grandfather SCH status for all existing SCHs while it further developing this policy. Similarly, several commenters suggested we further evaluate and develop this proposal and present it for public review and comment before finalizing the proposal.

One commenter stated that we should also consider adopting an altogether different approach. Rather than implement an objective, one-size-fits-all approach, we should instead develop review guidelines for our Regional Offices, and allow these Regional Offices to make case-by-case, fact-specific determinations using the guidelines. Such guidelines could, for example, utilize a quantitative evaluation, similar to what we proposed. In addition, Regional Offices could be directed to examine whether area beneficiaries have a choice in the area for general-acute care hospital services.

Response: We believe that, based on our understanding of the situations of which we are aware involving an SCH whose special status is being jeopardized by the opening of a limited-service specialty hospital in its service area, and similar situations described in the comments we received, an 8-percent threshold for the comparison of inpatient days as described above is appropriate. We are concerned that a case-by-case approach would result in inappropriate disparities across geographic areas in terms of how applications are reviewed.

C. Outlier Payments: Technical Change (§ 412.80)

Sections 1886(d)(5)(A) and (d)(5)(K) of the Act provide for payments, in addition to the basic prospective payments, for ''outlier'' cases; that is, cases involving extraordinarily high costs. Cases qualify for outlier payments by demonstrating costs that exceed a fixed loss cost outlier threshold equal to the prospective payment rate for the DRG plus any IME (§ 412.105) and DSH (§ 412.106) payments for the case and, for discharges on or after October 1, 2001, additional payments for new technologies or services.

Implementing regulations for outlier payments are located in subpart F of Part 412. Paragraph (a) of § 412.80 specifies the basic rules for making the additional outlier payments, broken down into three applicable effective periods. We have become aware that in paragraph (a)(2), which relates to outlier payments for discharges occurring on or after October 1, 1997, and before October 1, 2001, we did not include language to specify that the additional costs of outlier cases must exceed the standard DRG payment and any additional payment the hospital would receive for IME and for DSH, plus a fixed loss dollar threshold. Therefore, in the May 9, 2002 proposed rule, we proposed to make a technical change by revising § 412.80(a)(2), applicable for discharges occurring during the period between October 1, 1997 and October 1, 2001, to include the appropriate language regarding additional payments for IME and payments for DSH. (We note that when we amended § 412.80 to incorporate the provisions on the additional payments for new technology under paragraph (a)(3) (66 FR 46924, September 7, 2001), effective October 1, 2001, we did include this language.)

We did not receive any comments on this technical change.

D. Rural Referral Centers § 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the prospective payment system as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban amount rather than the rural standardized amount. Although the other urban and rural standardized amounts were the same for discharges beginning with that date, rural referral centers continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

As discussed in Federal Register documents at 62 FR 45999 and 63 FR 26317, under section 4202 of Public Law 105–33, a hospital that was classified as a rural referral center for FY 1991 is to be considered as a rural referral center for FY 1998 and later years so long as that hospital continues to be located in a rural area and does not voluntarily terminate its rural referral center status. Otherwise, a hospital seeking rural referral center status must satisfy applicable criteria.

Also, effective October 1, 2000, if a hospital located in what is now an urban area was ever a rural referral center, it was reinstated to rural referral center status (65 FR 47089).

One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use (§ 412.96(b)(ii)). A rural hospital that does not meet the bed size requirement can qualify as a rural referral center if the hospital meets two mandatory prerequisites (a minimum case-mix index and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume) (§ 412.96(c)(1) through (c)(5)). With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if—

- The hospital's case-mix index is at least equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

Section 412.96(c)(1) provides that CMS will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the proposed national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national mean case-mix index value for FY 2003 in the May 9, 2002 proposed rule included all urban hospitals nationwide, and the proposed regional values for FY 2003 were the median values of urban hospitals within each census region, excluding those with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105). These values were based on discharges occurring during FY 2001 (October 1, 2000 through September 30, 2001) and include bills posted to CMS's records through December 2001.

In the May 9, 2002 proposed rule, we proposed that, in addition to meeting

other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2002, must have a case-mix index value for FY 2001 that is at least—

- 1.3229; or
- The median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located. (See the table set forth in the May 9, 2002 proposed rule at 67 FR 31460).

Based on the latest data available (FY 2001 bills received through March 31, 2002), in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2002, must have a case-mix index value for FY 2002 that is at least—

- 1.3225; or
- The median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located. The final median case-mix index values by region are set forth in the following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2044
2. Middle Atlantic (PA, NJ, NY)	1.2247
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3014
4. East North Central (IL, IN, MI, OH, WI)	1.2345
5. East South Central (AL, KY, MS, TN)	1.2418
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1621
7. West South Central (AR, LA, OK, TX)	1.2595
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3162
9. Pacific (AK, CA, HI, OR, WA)	1.2785

Hospitals seeking to qualify as rural referral centers or those wishing to know how their case-mix index value compares to the criteria should obtain hospital-specific case-mix index values from their fiscal intermediaries. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2001 (that is, October 1, 2000 through September 30, 2001). FY 2001 is the latest year for which we have complete discharge data available.

Therefore, in the May 9, 2002 proposed rule, we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2002, must have as the number of discharges for its cost reporting period that began during FY 2001 a figure that is at least__

- 5,000; or
- The median number of discharges for urban hospitals in the census region in which the hospital is located. (See the table set forth in the May 9, 2002 proposed rule at 67 FR 31460.)

Based on the latest discharge data available for FY 2001, the final median number of discharges for urban hospitals by census region areas are as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6,905
2. Middle Atlantic (PA, NJ, NY)	8,644
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	8,893
4. East North Central (IL, IN, MI, OH, WI)	7,890
5. East South Central (AL, KY, MS, TN)	6,953
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5,696
7. West South Central (AR, LA, OK, TX)	6,226
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,167
9. Pacific (AK, CA, HI, OR, WA)	7,053

We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

We reiterate that if an osteopathic hospital is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 2002, the hospital must have at least 3,000 discharges for its cost reporting period that began during FY 2001.

We did not receive any comments on the criteria for rural referral centers.

E. Indirect Medical Education (IME) Adjustment (§ 412.105)

1. Background

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment for a Medicare discharge to reflect the higher indirect operating costs of teaching hospitals relative to nonteaching hospitals. The existing regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105. The additional payment is based on the

IME adjustment factor. The IME adjustment factor is calculated using a hospital's ratio of residents to beds, which is represented as *r*, and a multiplier, which is represented as *c*, in the following equation: $c \times [(1 + r)^{.405} - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio. Section 1886(d)(5)(B)(ii)(VII) of the Act provides that, for discharges occurring during FY 2003 and thereafter, the ''c'' variable, or formula multiplier, is 1.35. The formula multiplier of 1.35 represents a 5.5-percent increase in IME payment for every 10-percent increase in the resident-to-bed ratio.

2. Temporary Adjustments to the FTE Cap To Reflect Residents Affected by Residency Program Closure: Resident-to-Bed Ratio for Displaced Residents (§§ 412.105(a) and (f)(1)(ix))

In the August 1, 2001 hospital inpatient prospective payment system final rule (66 FR 39899), we expanded the policy at existing § 413.86(g)(8) (to be redesignated as § 413.86(g)(9)) which allows a temporary adjustment to a hospital's FTE cap when a hospital trains additional residents because of another hospital's closure, to also allow a temporary adjustment when a hospital trains residents displaced by the closure of another hospital's residency program (but the hospital itself remains open). We revised regulations at existing § 413.86(g)(8) to state that, if a hospital that closes a residency training program agrees to temporarily reduce its FTE cap, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the former hospital's residency training program. We defined ''closure of a hospital residency training program'' as when the hospital ceases to offer training for residents in a particular approved medical residency training program. The methodology for adjusting the caps for the ''receiving'' hospital and the ''hospital that closed its program'' as they apply to the IME adjustment and direct GME payments is set forth in the regulations at existing §§ 412.105(f)(1)(ix) and 413.86(g)(8)(iii), respectively.

In the final notice published in the **Federal Register** on August 1, 2001 rule, we noted a commenter who requested that CMS further revise the regulations to grant temporary relief to hospitals in calculating the IME adjustment with regard to application of the resident-to-bed ratio cap (66 FR 39900). The commenter believed that while the regulations provide for the cap on the number of residents to be temporarily adjusted, if the receiving hospital is not allowed to also adjust its resident-to-bed ratio in the prior year, the lower resident-to-bed ratio from the prior year could act to reduce the IME payments to the receiving hospital. The commenter suggested that, similar to the exception for residents in hospitals that begin new programs under § 412.105(a)(1), an adjustment should be made to the prior year's number of FTE residents, equal to the increase in the current year's FTEs that is attributable to the transferred residents. In response to the commenter, we stated that we had decided not to allow the exclusion of these displaced residents in applying the resident-to-bed ratio cap. We explained that, while we believed that the receiving hospital may be held to a lower cap in the first year of training the displaced residents, the receiving hospital would benefit from the higher cap in the subsequent years as the displaced residents complete their training and leave that hospital. However, we indicated that we would consider suggestions for possible future changes to this policy.

In the proposed regulation, we revisited this policy and explained that our rationale for not allowing the adjustment for displaced residents to the resident-to-bed ratio cap may have been faulty. We initially believed that, in the year following the last year in which displaced residents trained at the receiving hospital, the receiving hospital would benefit from the higher resident-to-bed ratio cap. However, we have determined that, while it is correct that the hospital will have a higher resident-to-bed ratio cap because of the higher number of displaced residents in the prior year, the receiving hospital's actual FTE count decreases as the displaced residents finish their training. Therefore, the receiving hospital would not need a higher resident-to-bed ratio in the prior year to accommodate the remaining FTEs. Consequently, the higher resident-to-bed ratio cap in fact would not benefit the receiving hospital. Thus, in the May 9, 2002 proposed rule, we proposed to allow the exclusion of residents displaced by either the closure of another hospital's program or another hospital's closure in applying the resident-to-bed ratio cap. Specifically, assuming a hospital is eligible to receive a temporary adjustment to its FTE cap as described in existing § 413.86(g)(8), we proposed that, solely for purposes of applying the resident-to-bed ratio cap in the *first* year in which the receiving hospital is training the displaced residents, the receiving hospital may adjust the numerator of the prior year's resident-to-bed ratio by the number of FTE residents that has caused the receiving hospital to exceed its FTE cap. (We note that, as we explain below in response to a comment, in this final rule we are revising the proposed language of § 412.105(a)(1)(iii) to state that the exception to the resident-to-bed ratio cap for closed hospitals and closed programs applies only through the end of the first 12-month cost reporting period in which the receiving hospital trains the displaced FTE residents. We further note that this adjustment to the resident-to-bed ratio cap does not apply to changes in bed size.) In the years subsequent to the first year in which the receiving hospital takes in the displaced residents, we believe an adjustment to the numerator of the prior year's resident-to-bed ratio is unnecessary because the receiving hospital's actual FTE count in those years would either stay the same or, as the displaced residents complete their training or leave that hospital, decrease each year. If all other variables remain constant, an increase in the current year's resident-to-bed ratio will establish a higher cap for the following year. In the second and subsequent years of training the displaced residents, the receiving hospital's resident-to-bed ratio for the current year would not be higher than the prior year's ratio and thus would not be limited by the resident-to-bed ratio cap.

In the cost reporting period following the departure of the last displaced residents, when the temporary FTE cap adjustment is no longer applicable, we proposed that, solely for purposes of applying the resident-to-bed ratio cap, the resident-to-bed ratio be calculated as if the displaced residents had not trained at the receiving hospital in the prior year. In other words, in the year that the hospital is no longer training displaced residents, the attendant FTEs should be removed from the numerator of the resident-to-bed ratio from the prior year (that is, the resident-to-bed ratio cap). We explained that because we proposed to allow the adjustment to the resident-to-bed ratio cap in the first year in which the receiving hospital trains displaced residents, it is equitable to remove those FTEs when calculating the resident-to-bed ratio cap after all the displaced residents have completed their training at the receiving hospital.

The following is an example of how the receiving hospital's IME resident-to-bed ratio cap would be adjusted for displaced residents coming from either a closed hospital or a closed program:

Example: Hospital A has a family practice program with 3 residents. On

June 30, 2002, Hospital A closes. Hospital B, which also has a family practice program, agrees to continue the training of Hospital A's residents beginning July 1, 2002. Its fiscal year end is June 30. As of July 1, 2002, the 3 residents displaced by the closure of Hospital A include 1 PGY1 resident, 1 PGY2 resident, and 1 PGY3 resident. In addition, Hospital B has 5 of its own residents, an IME FTE resident cap of 5, and 100 beds. Subject to the criteria under existing § 413.86(g)(8), Hospital B's FTE cap is temporarily increased to 8 FTEs. According to the proposed policy stated above, Hospital B's resident-to-bed ratio and resident-to-bed ratio cap would be determined as follows:

July 1, 2002 through June 30, 2003

• Resident-to-bed ratio: 5 FTEs + 3 displaced FTEs / 100 beds = .08 (line 3.18 of Worksheet E, Part A of the Medicare cost report, Form CMS 2552–96).

Note: For purposes of applying the rolling average calculation at § 412.105(f)(1)(v) to this example, it is assumed that Hospital B had 5 FTE residents in both the prior and the penultimate cost reporting periods. Therefore, 5 FTEs are used in the numerator of the resident-to-bed ratio. Under § 412.105(f)(1)(v), displaced residents are added to the receiving hospital's rolling average FTE count in each year that the displaced residents are training at the receiving hospital.)

• Resident-to-bed ratio cap: 5 FTEs (from fiscal year end June 30, 2002) + *3 displaced FTEs (from fiscal year end June 30, 2003)* / 100 beds = .08 (line 3.19 of Worksheet E, Part A of Form CMS 2552–96).

• The lower of the resident-to-bed ratio from the current year (.08) or the resident-to-bed ratio cap from the prior year (.08) is used to calculate the IME adjustment. Therefore, Hospital B would use a resident-to-bed ratio of .08 (line 3.20 of Worksheet E, Part A of Form CMS 2552–96).

July 1, 2003 through June 30, 2004

The PGY3 displaced resident has completed his or her family practice training on June 30, 2003 and has left Hospital B. Hospital B continues to train a displaced (now) PGY2 resident, and a displaced (now) PGY3 resident.

• Resident-to-bed ratio: 5 FTEs + 2 displaced FTEs / 100 beds = .07 (line 3.18 of Worksheet E, Part A of Form CMS 2552–96).

• Resident-to-bed ratio cap: 5 FTEs (from fiscal year end June 30, 2003) + 3 displaced FTEs (from fiscal year end June 30, 2003) / 100 beds = .08 (line 3.19 of Worksheet E, Part A of Form CMS 2552–96).

• The lower of the resident-to-bed ratio from the current year (.07) or the resident-to-bed ratio cap from the prior year (.08) is used to calculate the IME adjustment. Hospital B would use a resident-to-bed ratio of .07 (line 3.20 of Worksheet E, Part A of Form CMS 2552–96).

July 1, 2004 through June 30, 2005

Another of the remaining displaced residents has completed his or her family practice training on June 30, 2004 and has left Hospital B. Hospital B continues to train one displaced (now) PGY3 resident.

• Resident-to-bed ratio: 5 FTEs + 1 displaced FTE / 100 beds = .06 (line 3.18 of Worksheet E, Part A of Form CMS 2552–96).

• Resident-to-bed ratio cap: 5 FTEs (from fiscal year end June 30, 2004) + 2 displaced FTEs (from fiscal year end June 30, 2004) / 100 beds = .07 (line 3.19 of Worksheet E, Part A of Form CMS 2552–96).

• The lower of the resident-to-bed ratio from the current year (.06) or the resident-to-bed ratio cap from the prior year (.07) is used to calculate the IME adjustment. Hospital B would use a resident-to-bed ratio of .06 (line 3.20 of Worksheet E, Part A of Form CMS 2552–96).

July 1, 2005 through June 30, 2006

The last displaced resident has completed his or her family practice training on June 30, 2005 and has left Hospital B. Hospital B no longer trains any displaced residents, and, therefore, the last displaced resident is *removed* from the numerator of the resident-to-bed ratio cap.

• Resident-to-bed ratio: 5 FTEs + 0 displaced FTEs / 100 beds = .05

• Resident-to-bed ratio cap: 5 FTEs (from fiscal year end June 30, 2005) + *0 displaced FTEs (subtract 1 displaced FTE from FYE June 30, 2005)* / 100 beds = .05

• The lower of the resident-to-bed ratio from the current year (.05) or the resident-to-bed ratio cap from the prior year (.05) is used to calculate the IME adjustment. Hospital B would use a resident-to-bed ratio of .05.

We proposed that this exception to the resident-to-bed ratio cap for residents coming from a closed hospital or a closed program would be effective for cost reporting periods beginning on or after October 1, 2002, which was reflected in proposed revised § 412.105(a)(1).

Comment: Numerous commenters expressed support for our proposal to allow an adjustment to the resident-to-bed ratio cap for residents displaced by the closure of another teaching hospital or another hospital's GME program. One commenter added that, although the proposed adjustment to the resident-to-bed ratio in the first year would equitably reimburse hospitals who commence training the displaced residents at the beginning of their respective fiscal year, this adjustment would result in the receiving hospital being under-reimbursed in the first full year of residency training when a hospital or program closes toward the end of the receiving hospital's fiscal year. The commenter requested that CMS correct this inequity by extending the resident-to-bed ratio cap adjustment to include both the first partial and the first full year of training displaced residents at the receiving hospital.

Response: We agree with the commenter that our proposal to limit the adjustment to the resident-to-bed ratio cap to the first (cost reporting) year in which the receiving hospital is training the displaced residents may result in reduced payments to the receiving hospital if the receiving hospital begins training those residents at some point other than the beginning of a full fiscal year. Therefore, in this final rule, we are revising the language proposed under § 412.105(a)(1)(iii) to state that the exception to the resident-to-bed ratio cap for closed hospitals and closed programs applies through the end of the first 12-month cost reporting period in which the receiving hospital trains the displaced FTE residents. We note that the effective date of this revised policy is for cost reporting periods beginning on or after October 1, 2002.

For example, if receiving Hospital A has a fiscal year end (FYE) of December 31, 2003, and it begins training 3 displaced residents on November 1, 2003, for purposes of applying the resident-to-bed ratio cap, receiving Hospital A may add a 2 months' proportion of the 3 FTEs to the numerator of the resident-to-bed ratio cap from the prior cost reporting period (FYE December 31, 2002). Receiving Hospital A may also add the FTEs that continue training at the hospital during its cost reporting period ending December 31, 2004 to the numerator of the resident-to-bed ratio cap from the FY 2003 cost reporting period. However, no adjustment may be made for purposes of applying the resident-to-bed ratio cap for subsequent years. Other than the allowance for applying the resident-to-bed ratio cap adjustment through the end of the first 12-month cost reporting period in which the receiving hospital trains the displaced

residents, the policy is the same as that in the proposed rule.

Comment: One commenter commended CMS for realizing that it would be appropriate to allow eligible hospitals to receive a temporary adjustment to the application of the IME resident-to-bed ratio cap. However, the commenter believed that in lieu of the rationale that CMS utilized in drafting the regulation published on August 1, 2001 and to avoid penalizing eligible hospitals, CMS should apply a retroactive effective date of October 1, 2001 to this policy.

Response: We understand the commenter's concerns, and in proposing this policy, we acknowledged the need to allow for the temporary adjustment to the resident-to-bed ratio cap. However, because we do not have explicit statutory authority to do so, we are unable to apply this policy retroactively. Therefore, the effective date of this policy will be prospective; that is, for cost reporting periods beginning on or after October 1, 2002.

Comment: Some commenters asserted that the proposal requiring that the resident-to-bed ratio cap be calculated in the cost reporting period following the departure of the last displaced residents as if the displaced residents had not trained at the receiving hospital in the prior year, adds more complexity to an already burdensome IME calculation. The commenters stated that the number of residents likely to be involved with this provision is minimal, and accordingly, CMS should not finalize this provision.

Response: As we have explained in the proposed rule, we believe that in light of the addition of FTEs to the resident-to-bed ratio cap in the first full cost reporting period, it is equitable to remove those FTEs when calculating the resident-to-bed ratio cap in the year following the departure of the displaced residents. We disagree that requiring that the resident-to-bed ratio cap be calculated in the cost reporting period following the departure of the last displaced residents as if the displaced residents had not trained at the receiving hospital in the prior year is overly burdensome. It requires only a simple subtraction of FTEs from the numerator of the prior year ratio, and in the next issuance of the Medicare cost report instructions, we will be making a revision to the instructions for line 3.19 of Worksheet E, Part A of the cost report to reflect this policy.

Comment: One commenter was concerned about our proposal to adjust ''the numerator of the prior year's resident-to-bed ratio *by the number of FTE residents that has caused the receiving hospitals to exceed its FTE cap''* (emphasis added) (67 FR 31461, May 9, 2002). The commenter stated that, by describing the increase in the numerator in relation to the hospital's FTE cap, the intent of the provision will not be fulfilled unless the hospital is already at its FTE cap. The commenter explained that if, for example, Hospital A has 4 residents in both cost reporting years 2002 and 2003, has a FTE cap of 5 FTEs, and accepts 3 displaced residents in 2003, it exceeds the FTE cap by only 2 residents. Therefore, as proposed, the adjustment to the prior year resident-to-bed ratio would result in a ratio cap of 0.06 ((4+2)/100). The current year resident-to-bed ratio would be 0.07 ((4+3)/100). Since this exceeds the hospital's prior year resident-to-bed ratio, the resident-to-bed ratio for Hospital A will be held to 0.06. The commenter concluded that since our intent is not to penalize hospitals that accept displaced residents, the adjustment to the prior year resident-to-bed ratio must not rely on the FTE cap for a reference point, but rather, must equal the number of displaced residents.

Response: The original regulations concerning temporary adjustments for hospital closure were written in response to requests from hospitals for an exception to the FTE cap, to allow the additional residents coming from a closed hospital to be counted by the receiving hospital (63 FR 26329 and 26329, May 12, 1998). Similarly, in the July 30, 1999 final rule (64 FR 41522), we explained that we adopted this provision because hospitals had indicated a reluctance to accept additional residents from a closed hospital without a temporary adjustment to their FTE caps. Accordingly, the existing regulations discussing hospital and program closure at § 413.86(g)(8) (§ 412.105(f)(1)(ix) for IME) state that ''a hospital may receive a temporary adjustment to its FTE cap to reflect residents added'' because of the closure of another hospital or another hospital's program. Furthermore, existing §§ 413.86(g)(8)(ii)(B) and (g)(8)(iii)(A)(*2*) require that, in order for a hospital to receive this temporary FTE cap adjustment, the hospital must document ''that it is eligible for this temporary adjustment by identifying the residents who have * * * *caused the hospital to exceed its cap.* * * *'' (emphasis added). These regulations are only applicable in instances where the training of displaced residents causes a hospital to exceed its FTE cap; if a hospital has room under its FTE cap to train these residents, no FTE cap adjustment is needed. Thus, in order for a hospital to qualify for an adjustment to its resident-to-bed ratio cap (or 3-year rolling average count), the hospital must first qualify for a temporary adjustment to its FTE cap. To qualify for a temporary FTE cap adjustment, the hospital must demonstrate that accepting some number of displaced residents has caused the hospital to exceed its FTE cap. Therefore, the proposed resident-to-bed ratio cap adjustment is necessarily linked to ''the number of FTE residents that has caused the hospital to exceed its FTE cap.'' Accordingly, we are not accepting the commenter's request at this time. However, we may consider in the future proposing to allow hospitals that are below their FTE caps and train displaced residents to also receive an adjustment for those displaced residents that are under the cap for purposes of applying the resident-to-bed ratio cap and the 3-year rolling average. As a final note, we would like to point out an error in the example that the commenter provided. In the example, a hospital that has 4 FTEs and an FTE cap of 5, accepts 3 displaced FTE residents. The commenter stated that the current year resident-to-bed ratio would be 0.07 ((4+3)/100). This is incorrect. Since, as explained above, the regulations prescribe that the receiving hospital's FTE count is only adjusted for those FTEs that have caused the receiving hospital to exceed its FTE cap, the current year numerator (as well as the prior year numerator) would be 6 (4+2), because only 2 of the 3 FTEs have caused the hospital to exceed its FTE cap of 5 FTEs.

Comment: One commenter requested CMS to allow hospitals that train displaced residents to receive permanent, not temporary, adjustments to their FTE caps.

Response: We are not addressing this comment in this final rule because it is outside the scope of what was specifically addressed in the proposed rule.

3. Counting Beds for the IME and DSH Adjustments (§ 412.105(b) and § 412.106(a)(l)(i))

In the May 9, 2002 proposed rule, we discussed the regulations located at § 412.105(b) for determining the number of beds to be used in calculating the resident-to-bed ratio for the IME adjustment. Those regulations also are used to determine the number of beds for other purposes, including calculating the DSH adjustment at § 412.106(a)(l)(i). Section 412.105(b) specifies that the number of beds in a hospital is determined by counting the number of available bed days during the

cost reporting period and dividing that number by the number of days in the cost reporting period. The number of available bed days does not include beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units.

We also discussed section 2405.3G of Part I of the Medicare Provider Reimbursement Manual (PRM), which further defines an ''available'' bed as a bed that is permanently maintained and is available for use to lodge inpatients.

These discussions were background for our proposal to clarify some of the uncertainty that had arisen concerning the application of the definition of ''available.'' For example, a question has arisen as to whether beds in rooms or entire units that are unoccupied for extended periods of time should continue to be counted on the basis that, if there would ever be a need, they could be put into use.

Counting the number of beds in a hospital is intended to measure the size of a hospital's routine acute care inpatient operations. While hospitals necessarily maintain some excess capacity, we believe there is a point where excess capacity may distort the bed count. Therefore, we proposed to revise our policy concerning the determination of a hospital's bed size to exclude beds that represent an excessive level of unused capacity. We stated that the proposed refinement of our bed counting policy would better capture the size of a hospital's inpatient operations as described above.

We analyzed Medicare hospital data and found that, among hospitals that have between 100 and 130 beds, hospitals receiving DSH payments have lower occupancy rates than similar hospitals not receiving DSH payments. Because DSH payments are higher for urban hospitals with more than 100 beds, there may be an incentive for these hospitals to maintain excess capacity in order to qualify for those higher payments. Among 189 urban hospitals in this bed-size range that did not receive DSH payments during FY 1999, the average occupancy rate was 55 percent. However, among 294 urban hospitals in this bed-size range that did receive DSH payments during FY 1999, the average occupancy rate was 47 percent. Twenty-five percent of this group of hospitals (those receiving DSH payments) had occupancy rates below 35 percent. Among the hospitals not receiving DSH payments, 25 percent had occupancy rates below 43 percent. We believe this is indicative of a tendency among some small urban hospitals to maintain excess capacity in order to qualify for higher DSH payments. Therefore, we proposed that if a hospital's reported bed count results in an occupancy rate (average daily census of patients divided by number of beds) below 35 percent, the applicable bed count, for purposes of establishing the number of available beds for that hospital, would exclude beds that would result in an average annual occupancy rate below 35 percent (proposed § 412.105(b)(3)).

For example, if a hospital reports 105 beds for a cost reporting period, but has an average daily census of 26 patients for that same cost reporting period, its occupancy rate equals 24.8 percent (that is, 26/105). Because its occupancy rate is below the proposed minimum threshold of 35 percent, its maximum available bed count would be 74, which is the number of beds that would result in an occupancy rate of 35 percent, given an average daily census of 26 patients(that is, 26/.35).

We proposed to otherwise continue to determine a hospital's bed size using existing regulations and program manual instructions, including the application of the available bed policy.

We believe that the policy in the May 9, 2002 proposed rule more accurately indicates the size of a hospital's operations. We proposed to specify under § 412.105(b)(3) that if a hospital's reported bed count results in an occupancy rate below 35 percent, the applicable bed count for that hospital would be the number of beds that would result in an occupancy rate of 35 percent. We proposed to make the proposed policy effective for discharges occurring on or after October 1, 2002.

Comment: Numerous commenters questioned why we were interested in applying an occupancy adjustment to counting beds for IME and DSH purposes. The commenters strongly opposed the proposed policy, which they indicated would serve to increase a hospital's IME payment but would limit a hospital's bed size for DSH payment purposes, if the hospital's occupancy is below 35 percent. In addition, the commenters believed that there are other reasons why a hospital may have excess capacity that may include patients utilizing the outpatient services instead of inpatient services, and that, due to cost, patients may be moved sooner from acute care settings to the next level of care.

The commenters contended that this proposal is contrary to the statutory language and congressional intent. The commenters further contended that the proposed policy would cause financial hardship to small urban hospitals that treat a disproportionate number of low-income patients.

MedPAC indicated that it believed that we are recognizing a real problem in maintaining integrity in the DSH payment procedures. However, MedPAC believed that the proposed policy illustrates the difficulties that arise when qualifying for DSH payments depends in part on the number of beds a hospital keeps in service. MedPAC recommended that a single formula apply to all hospitals regardless of location (urban/rural) or bed size. In addition, MedPAC recommended that the low-income shares used to determine each hospital's DSH adjustment reflect all low-income patients, which include patients receiving uncompensated care. MedPAC stated that a new DSH distribution formula will be needed when the uncompensated care data are complete, and that would be an opportune time to eliminate the use of a bed standard. Based on this information, MedPAC questioned whether it is worth changing the bed counting methodology now since a more fundamental change may occur in the next year or two.

Response: We believe our proposed policy represents a reasonable approach to addressing situations where hospitals appear to be maintaining excess capacity in order to qualify for higher DSH payments. With respect to our authority to implement such a change, we point out that we have broad authority under the statute in establishing the methodology for determining the number of available beds.

However, at this time, we have decided not to proceed with the proposed change. Instead, we will consider this issue as part of a future comprehensive analysis of our bed and patient day counting policies. That is, we believe there are other aspects of counting beds that need to be addressed as well and, upon further consideration, we have decided to proceed in a more comprehensive manner. We acknowledge MedPAC's comments as well and will take into account the potential that bed counting issues for DSH purposes may become less significant.

Accordingly, in this final rule, we are not adopting the proposed change of § 412.105(b)(3).

Technical Correction

Section 211(b) of Public Law 106–554 amended section 1886(d)(5)(F)(iv)(III) of the Act to revise the calculation of the DSH payment adjustment for hospitals affected by the revised thresholds as specified in section 211(a) of Public Law

106–554. These changes were effective for discharges on or after April 1, 2001, and no changes were made by section 211(b) for discharges prior to April 1, 2001. When we issued the June 13, 2001 interim final rule with comment period (66 FR 32172) to update the regulations to incorporate the changes made by section 211, we inadvertently changed the adjustment factor for rural hospitals with fewer than 100 beds from 4 percent to 5 percent under § 412.106(d)(2)(iv)(A) for discharges occurring before April 1, 2001. We are correcting this error in this final rule by revising § 412.106(d)(2)(iv)(A) to specify that, for discharges before April 1, 2001, the applicable DSH adjustment factor for rural hospitals with fewer than 100 beds was 4 percent.

This correction was not included in the May 9, 2002 proposed rule, as we were only made aware of it after publication of that proposed rule. The Administrative Procedure Act generally requires that agency rules be published in the **Federal Register** as a notice of proposed rulemaking with a period for public comment (5 U.S.C. 533(b)). This notice-and-comment procedure can be waived, however, if an agency finds good cause that the procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. Since this change is being made to correct a technical error, we find that the notice-and-comment procedure is unnecessary, and, therefore, find good cause to waive the notice of proposed rulemaking and issue the correction in this final rule.

F. Medicare-Dependent, Small Rural Hospitals: Ongoing Review of Eligibility Criteria (§ 412.108(b))

Section 6003(f) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) added section 1886(d)(5)(G) to the Act and created the category of Medicare-dependent, small rural hospitals (MDHs). MDHs are eligible for a special payment adjustment under the acute care hospital inpatient prospective payment system. Initially, in order to be classified as an MDH, a hospital must have met all of the following criteria:

- The hospital is located in a rural area (as defined in § 412.63(b);
- The hospital has 100 or fewer beds (as defined at § 412.105(b)) during the cost reporting period;
- The hospital is not classified as an SCH (as defined at § 412.92); and
- The hospital has no less than 60 percent of its inpatient days or discharges attributable to inpatients receiving Medicare Part A benefits during its cost reporting period beginning in FY 1987.

MDHs were eligible for a special payment adjustment under the acute care hospital inpatient prospective payment system, effective for cost reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993. Hospitals classified as MDHs were paid using the same methodology applicable to SCHs, that is, based on whichever of the following rates yielded the greatest aggregate payment for the cost reporting period:

- The national Federal rate applicable to the hospital.

The updated hospital-specific rate based on FY 1982 costs per discharge.

The updated hospital-specific rate based on FY 1987 costs per discharge.

Section 13501(e)(1) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66) extended the MDH provision through FY 1994 and provided that, after the hospital's first three 12-month cost reporting periods beginning on or after April 1, 1990, the additional payment to an MDH whose applicable hospital-specific rate exceeded the Federal rate was limited to 50 percent of the amount by which the hospital-specific rate exceeded the Federal rate. The MDH provision expired effective with cost reporting periods beginning on or after October 1, 1994.

Section 4204(a)(3) of Public Law 105–33 reinstated the MDH special payment for discharges occurring on or after October 1, 1997 and before October 1, 2001, but did not revise the qualifying criteria for these hospitals or the payment methodology.

Section 404(a) of Public Law 106–113 extended the MDH provision to discharges occurring before October 1, 2006.

As specified in the June 13, 2001 interim final rule with comment period (66 FR 32172) and finalized in the August 1, 2001 final rule (66 FR 39883), section 212 of Public Law 106–554 provided that, effective with cost reporting periods beginning on or after April 1, 2001, a hospital has the option to base MDH eligibility on two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report, rather than on the cost reporting period that began during FY 1987 (section 1886(d)(5)(G)(iv)(IV) of the Act). According to section 1886(d)(5)(G)(iv)(IV) of the Act, the criteria for at least 60 percent Medicare utilization will be met if, in at least ''2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report'', at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals receiving Medicare Part A benefits.

We would like to point out that cost reports undergo different levels of review. For example, some cost reports are settled with a desk review; others, through a full field audit. We believe the intention of the law is to provide hospitals the ability to qualify for MDH status based on their most recent settled cost reporting periods, each of which undergoes a level of audit in its settlement.

Hospitals that qualify under section 1886(d)(5)(G)(iv)(IV) of the Act are subject to the other provisions already in place for MDHs. That is, all MDHs are paid using the payment methodology as defined in § 412.108(c) and may be eligible for the volume decrease provision as defined in § 412.108(d).

Under existing classification procedures at § 412.108(b), a hospital must submit a written request to its fiscal intermediary to be considered for MDH status based on at least two of its three most recently audited cost reporting periods for which the Secretary has a settled cost report (as specified in § 412.108(a)(1)(iii)(c)). The fiscal intermediary will make its determination and notify the hospital within 90 days from the date it receives the hospital's request and all of the required documentation. The intermediary's determination is subject to review under 42 CFR part 405, Subpart R. MDH status is effective 30 days after the date of written notification of approval.

In the May 9, 2002 proposed rule, we proposed to clarify and to codify in the regulations (proposed § 412.108(b)(4)) that an approved classification as an MDH remains in effect unless there is a change in the circumstances under which the classification was approved. That is, in order to maintain its eligibility for MDH status, a hospital must continue to be a small (100 or fewer beds), rural hospital, with no less than 60 percent Medicare inpatient days or discharges during either its cost reporting period beginning in FY 1987 or during at least two of its three most recently settled cost reporting periods.

We also proposed to clarify and to codify in the regulations (proposed § 412.108(b)(5)) that the fiscal intermediary will evaluate on an ongoing basis whether or not a hospital continues to qualify for MDH status. This proposed clarification included evaluating whether or not a hospital that qualified for MDH status under section 1886(d)(5)(G)(iv)(IV) of the Act continues to qualify for MDH status

based on at least two of its three most recently settled cost reporting periods.

In addition, we proposed (proposed § 412.108(b)(6)) that if a hospital loses its MDH status, that change in status would become effective 30 days after the fiscal intermediary provides written notification to the hospital that it no longer meets the MDH criteria. If the hospital would like to be considered for MDH status after another cost reporting period has been audited and settled, we proposed to require that the hospital must reapply by submitting a written request to its fiscal intermediary (proposed § 412.108(b)(7)). An MDH that continues to meet the criteria would not have to reapply.

Comment: Three commenters addressed our proposal to conduct ongoing reviews of hospitals to determine whether or not they continue to meet the MDH criteria. The first commenter opposed the proposal for ongoing reviews of MDHs because this type of review is not specified in the law, but is an interpretation by CMS. The commenter supported its position by pointing out that a hospital qualifying based on the original criterion (that is, 1987 data) is allowed to retain this status despite any changes in subsequent years. The commenter also stated this may cause instability in individual hospital payments from year-to-year, which will be disruptive for a hospital whose revenue depends heavily on Medicare. The commenter suggested that, if the proposed reviews are found to be consistent with Congressional intent, CMS adopt a policy that does not penalize hospitals for small changes in patient mix and provides stability in the payment system from year to year. Moreover, the commenter suggested granting MDH status for a 3-year period before requiring requalification, similar to wage index reclassifications, or setting the level for requalification at a slightly lower level (perhaps 55 percent) so that a slight change in volume does not cause a loss of MDH status.

The second commenter supported the proposal but recommended that the requirement that hospitals apply for MDH status be removed, since the fiscal intermediaries will be conducting annual reviews.

The third commenter focused on the loss of MDH status effective 30 days after the intermediary provides written notification to the hospital that it no longer qualifies for MDH status. The commenter stated that mid-year MDH status changes provide a number of claims processing and cost report settlement problems. The commenter recommended that the effective date for the change in MDH status should be the first day of the cost reporting period following the intermediary's notification of the hospital.

Response: We agree that hospitals that qualify based on the original criteria were not required to requalify based on more recent data, since the original criteria, as dictated by law, was based on a specified period, here the 1987 data. However, the law was amended and specifies the new, additional criterion: ''two of the three most recently audited cost reporting periods for which the Secretary has a settled cost report.'' We believe this language supports an interpretation that a hospital is to qualify as an MDH based on its most recent data, not based on a one-time qualification, as is the case with the original criteria (which was based on data from a set period of time, the hospital's FY 1987 cost reporting period).

With respect to the suggestion that the proposed ongoing reviews of hospitals MDH status should provide that, once approved, retention of a hospital's MDH status for a 3-year period, or that the level for requalification should be at a slightly lower percentage of inpatient days or discharges attributable to Medicare than 60 percent, the statute (section 1886(d)(5)(G)(iv)(IV) of the Act) does not provide such flexibility. Allowing hospitals to qualify using cost report data from other than two of the three most recently available cost reporting periods, or using a percentage less than 60 percent, would be inconsistent with the statutory language.

Regarding the effective date of a status change, the effective date of 30 days after the date of the notice from the fiscal intermediary is consistent with current policy for approval of both MDH and SCH status as well as notices that the hospital no longer meets such eligibility criteria. Concerning the commenter's request to not require hospitals to reapply for MDHs status since the intermediaries would already be reviewing that status on an annual basis, we wish to clarify that the ongoing reviews would be of hospitals with existing MDHs status only. Therefore, hospitals that had lost their MDH status would not be included in an automatic annual review to determine whether or not the hospitals continue to meet the eligibility criteria for MDH status. Instead, such hospitals must reapply for MDH status based on two of their three most recently audited cost reports.

Accordingly, we are adopting as final the proposed revised changes to the MDH policy under § 412.108(b).

G. Eligibility Criteria for Reasonable Cost Payments to Rural Hospitals for Nonphysician Anesthetists (§ 412.113(c))

Currently, a rural hospital can qualify and be paid on a reasonable cost basis for qualified nonphysician anesthetists (certified registered nurse anesthetists (CRNAs) and anesthesiologist assistants) services for a calendar year beyond 1990 and subsequent years as long as it can establish before January 1 of that year that it did not provide more than 500 surgical procedures requiring anesthesia services, both inpatient and outpatient.

In the September 1, 1983 interim final rule with comment period that implemented the acute care hospital inpatient prospective payment system, we established the general policy to include, under that prospective payment system, inpatient hospital services furnished incident to a physician's service, with a time-limited exception for the inpatient hospital services of anesthetists (48 FR 39794). The purpose of this exception, which originally was for cost reporting periods beginning before October 1, 1986, was that the practice of physician-employer and anesthetist-employee was so widespread that we believed ''it would be disruptive of medical practice and adverse to the quality of patient care to require all such contracts to be renegotiated in the limited time available before the implementation of the prospective payment system.''

Section 2312 of Public Law 98–369 provided for reimbursement to hospitals on a reasonable cost basis as a pass-through for the costs that hospitals incur in connection with the services of CRNAs.[1] Section 2312(c) provided that the amendment was effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987.

Section 9320 of Public Law 99–509 (which established a fee schedule for the services of nurse anesthetists) amended section 2312(c) of Public Law 98–369 by extending the pass-through provision for cost reporting periods beginning before January 1, 1989. Section 608 of Public Law 100–485 limited the pass-through provision effective during 1989, 1990, and 1991, to hospitals meeting the following criteria:

[1] We noted in the August 31, 1984 final rule that section 2312 and the Conference Report used the term ''CRNA'' throughout. However, we believed it was Congressional intent to apply this pass-through payment amount to the services of all qualified hospital-employed nonphysician anesthetists (49 FR 34748).

• As of January 1, 1988, the hospital employed or contracted with a certified nonphysician anesthetist;

• In 1987, the hospital had a volume of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services that did not exceed 250 (or such higher number as the Secretary determines to be appropriate); and

• Each certified nonphysician anesthetist employed by, or under contract with, the hospital has agreed not to bill under Part B of Medicare for professional services furnished by the anesthetist at the hospital.

Subsequently, section 6132 of Public Law 101–239 amended section 608 of Public Law 100–458 by raising the established 250-procedure threshold to 500 procedures (effective for anesthesia services furnished on or after January 1, 1990), and extended the cost pass-through indefinitely. However, section 6132 of Public Law 101–239 left intact the requirement that the hospital must have not exceeded a maximum number of surgical procedures (effectively raised to 500), both inpatient and outpatient, requiring anesthesia services during 1987. Also, the statutory authority for the Secretary to adopt such other appropriate maximum threshold volume of procedures as determined appropriate was not affected by section 6132.

In light of the age of this provision, we undertook to reexamine the appropriateness of the current 500-procedure threshold. Nonphysician anesthetists who are not employed by or have a contractual relationship with a hospital paid under this provision may receive payments under a fee schedule. Payments under the fee schedule are generally somewhat lower than those made on a reasonable cost basis. Therefore, hospitals that exceed 500 procedures may have difficulty retaining access to nonphysician anesthetists' services because cost reimbursement is unavailable. According to data from the American Association of Nurse Anesthetists (AANA), the average salary for a CRNA in rural areas in calendar year 2000 was $111,000, with a total annual compensation of $141,000. The AANA estimates that, based on payments under the Medicare fee schedule, a CRNA would have to provide at least 800 anesthesia procedures to reach this average level of compensation.

The statute provides the Secretary with the authority to determine the appropriateness of the volume threshold, in part, so that changes necessary to meet the needs of rural hospitals can be made. As we have found that hospitals that exceed the 500 surgical procedures may have difficulty in retaining access to nonphysician anesthetists' services, we believe that the appropriate maximum threshold for surgical procedures should be raised in order for the payment exception to apply to those hospitals most in need of this payment treatment. Based upon the data available to us concerning the best estimates of average total compensation to a CRNA, we believe that the maximum volume threshold for surgical procedures requiring anesthesia services should be raised to 800. Therefore, to ensure continued access to nonphysician anesthetists' services in rural hospitals, in the May 9, 2002 proposed rule, we proposed to revise §§ 412.113(c)(2)(ii) and (c)(2)(iii) to raise the 500-procedure threshold to 800 procedures.

Comment: Several commenters supported our proposed changes and indicated that, without the proposed change in the regulations, rural hospitals will experience serious disruptions in their delivery of anesthesia services. CRNAs are the sole anesthesia providers in a number of rural hospitals. The commenters added that, without CRNAs, these rural hospitals will have difficulty in continuing to meet their patient's surgical and trauma stabilization services. Patients will be forced to travel outside of their communities, which could mean great distance.

One commenter suggested that the threshold should be reviewed every 3 years to ensure it continues to appropriately reflect market conditions for rural hospitals trying to maintain anesthetists services.

Response: We agree that the existing regulation providing for 500 procedures per year as a threshold could hinder the ability of some rural hospitals to sustain access to surgical procedures, which is the reason for our proposed change. We will continue to monitor this issue to determine whether future adjustments to the procedure threshold are warranted.

Comment: Several commenters raised an issue concerning the fact that some Medicare fiscal intermediaries include nonanesthesia ancillary services provided by the CRNAs when counting the total number of surgical procedures. They indicated that many rural hospitals are not able to qualify for the reasonable cost payment for their CRNAs as a result.

The commenters suggested a specific definition of surgical procedures that include cutting, abrading, suturing, and lasering of otherwise physically changing body tissues and organs. The commenters indicated that this suggested definition would clarify and eliminate the confusion in regulatory interpretation across fiscal intermediaries. One commenter indicated that anesthetists may provide therapeutic services for pain management unassociated with a surgical procedure.

Response: In view of the comments on this issue, we believe that certain steps are needed to improve consistency in the counting of surgical procedures. We appreciate the commenter's recommended definition of surgical procedures, and will consider whether such instructions would reduce inconsistency in counting of procedures, while still being consistent with the legislative and regulatory intent of this provision. We also will review all aspects of the counting of procedures to consider what further actions may be necessary to improve consistency. Our goal is to facilitate greater consistency in the manner and criteria used by all intermediaries.

Comment: Several commenters expressed concern that the existing regulations only allow hospitals in existence as of 1987 to qualify for reasonable cost pass-through and requested us to review this issue. The commenters indicated that this threatens new rural hospitals' ability to continue to provide surgical and anesthesia services to patients.

Response: To enable rural hospitals to secure anesthesia services for their patients, these regulations include a rural hospital's option for reasonable cost pass-through for the services of one full-time equivalent CRNA, as long as the hospital qualifies for ''pass-through'' treatment. The statute specifies the criteria and the regulation tracks the statutory language. Therefore, we believe we do not have the authority to extend this provision to hospitals that do not otherwise meet the criteria as described by the statute.

Comment: Some commenters sought clarification as to whether this provision is available to SCHs.

Response: SCHs that otherwise meet the statutory criteria are eligible to receive this pass-through payment. We are not aware that there has been any confusion in the past on this issue, but we are clarifying the point here in response to the comment.

Comment: Several commenters recommended that we eliminate the threshold altogether, or raise it even higher. One commenter stated that the need for the pass-through demonstrates that fee schedule payments for nonphysician anesthetists are inadequate to defray the costs associated with this service.

Another commenter suggested that CAHs should be exempt from the qualifying criteria to receive these pass-through payments. The commenter suggested that removing this requirement for CAHs would eliminate the unnecessary paperwork required for these hospitals to demonstrate they continue to meet the minimum thresholds.

A third commenter argued that the cost pass-through provision should permit rural hospitals to qualify on the basis of employing anesthesiologists as well. This commenter referred to survey data that purported to show a serious shortage of anesthesia providers in support of this argument.

Response: As described above, we believe the statute is specific as to the threshold requirements to qualify for the CRNA pass-through payments. Accordingly, a hospital or CAH that wishes to qualify for CRNA pass-through payments must meet the statutory criteria, including the threshold requirement. We also believe the statute does not provide authority to expand this policy to pay pass-through costs to hospitals for anesthesiologists' services. We believe the change we are making, increase the threshold from 500 to 800 procedures per year, is appropriate and note that it is generally supported by the commenters.

Comment: The AANA requested a technical correction to the reference in the proposed rule that, according to data from AANA, the average total annual compensation for CRNA in 2001 is approximately $155,000. According to the AANA, the most recent data for calendar year 2000 reflect an average salary in rural areas of $111,000, with a total annual compensation of $141,000.

Response: In the preamble of this final rule, we have revised the prior reference accordingly to avoid any potential confusion.

Comment: One commenter questioned whether anesthesiologists assistants are recognized as qualified providers under this provision.

Response: As we noted in the proposed rule and in the discussion above, our understanding of Congressional intent was that this pass-through payment applied to the services of all qualified hospital-employed nonphysician anesthetists (67 FR 31464). Therefore, a hospital otherwise meeting the criteria for this pass-through payment by employing an anesthesiologists assistant would be eligible for pass-though payments.

Comment: One commenter requested clarification of whether the requirement at § 412.113(c)(2)(i)(D) that ''each qualified nonphysician anesthetist employed by or under contract with the hospital or CAH has agreed in writing not to bill on a reasonable charge basis for his or her patient care in that hospital or CAH'' applies only to Medicare beneficiaries or to all patients.

Response: This requirement is to ensure that the nonphysician anesthetist is not also billing Medicare for Part B services under the fee schedule. Therefore, the requirement only pertains to services provided to Medicare beneficiaries. In this final rule, we are adding a revision to § 412.113(c)(2)(i)(D) to reflect the limited applicability of this requirement.

Accordingly, we are adopting as final the proposed changes to § 412.113(c)(2)(ii) and (c)(2)(iii), with one change. We are revising § 412.113(c)(2)(i)(D) to specify that each qualified nonphysician anesthetist employed by or under contract with the hospital or CAH has agreed in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.

H. Medicare Geographic Classification Review Board (MGCRB) Reclassification Process (§§ 412.230, 412.232, and 412.273)

With the creation of the MGCRB, beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). Implementing regulations in Subpart L of Part 412 (§§ 412.230 *et seq.*) set forth criteria and conditions for redesignations from rural to urban, rural to rural, or from an urban area to another urban area, with special rules for SCHs and rural referral centers.

1. Withdrawals, Terminations, and Cancellations

Under § 412.273(a) of our regulations, a hospital or hospital group may withdraw its application for reclassification at any time before the MGCRB issues its decision or, if after the MGCRB issues its decision, within 45 days after publication of our annual notice of proposed rulemaking concerning changes to the acute care hospital inpatient prospective payment system for the upcoming fiscal year (for example, the May 9, 2002 proposed rule for FY 2003). In the August 1, 2001 final rule, we specified that, for purposes of implementing section 304 of Public Law 106–554, the withdrawal procedures and the applicable timeframes in the existing regulations would apply to hospitals that receive 3-year reclassification for wage index purposes (66 FR 39886). Once effective, a withdrawal means that the hospital would not be reclassified for purposes of the wage index for FY 2003 (and would not receive continued reclassification for FYs 2004 and 2005), unless the hospital subsequently cancels its withdrawal. The procedure for canceling a withdrawal or termination is discussed in detail below.

Consistent with section 1886(d)(10)(D)(v) of the Act, a hospital may terminate its approved 3-year reclassification during the second or third years (§ 412.273(b)). This is a separate action from a reclassification withdrawal that occurs in accordance with the timeframes described above. Currently, in order to terminate an approved 3-year reclassification, we require the hospital to notify the MGCRB in writing within 45 days after the publication date of the annual proposed rule for changes to the hospital inpatient prospective payment system (§ 412.273(b)(1)(i)). A termination, unless subsequently cancelled, is effective for the full fiscal years remaining in the 3-year period.

We also provided that a hospital may apply for reclassification to a different area for the year corresponding to the second or third year of the reclassification (that is, an area different from the one to which it was originally reclassified) and, if successful, the reclassification would be for 3 years. Since the publication of the August 1, 2001 (FY 2002) final rule, we received an inquiry regarding a situation where a hospital with an existing 3-year wage index reclassification successfully reclassifies to a different area, then withdraws from that second reclassification within the allowable timeframe for withdrawals. This scenario raises several issues not specifically covered in the August 1, 2001 final rule, which we are addressing in this final rule.

For example, the question arises, at what point does a hospital's termination of a 3-year reclassification become effective when a hospital applies for reclassification to another area? As noted above, the August 1, 2001 final rule specified that a hospital must file a written request with the MGCRB within 45 days after publication of the annual proposed rule to terminate the reclassification. However, the rules do not specify at what point a previous 3-year reclassification is terminated when

a hospital applies for reclassification to another area in subsequent years. One might conclude that an application for a wage index reclassification to another area constitutes a written notification of a hospital's intent to terminate an existing 3-year reclassification. Under this scenario, however, if the application to the second area were denied, it would then be necessary for the hospital to formally cancel the termination of its reclassification to the first area to avoid a lapse in reclassification status the following year. Therefore, in the May 9, 2002 proposed rule, we proposed to clarify, in new paragraph (iii) of § 412.273(b)(2), that, in a situation where a hospital with an existing 3-year wage index reclassification applies to be reclassified to another area, its existing 3-year reclassification will be terminated when a second 3-year wage index reclassification goes into effect for payments for discharges on or after the following October 1. In such a case, it will not be necessary for the hospital to submit a separate written notice of its intent to terminate its existing 3-year reclassification. Of course, a hospital also may still terminate an existing 3-year reclassification through written notice to the MGCRB, regardless of whether it successfully reclassifies to a different area.

The scenario of a hospital with an existing 3-year reclassification seeking reclassification to a second area raises another issue. If the hospital's request is approved by the MGCRB, but the hospital withdraws from that successful reclassification and ''falls back'' to its original 3-year reclassification, does the hospital retain the right to cancel that withdrawal the next year? In this way, a hospital could accumulate multiple reclassification options from which it could choose in any given year through canceling prior withdrawals or terminations to one area and withdrawing or terminating reclassifications to other areas.

We do not believe section 304 of Public Law 106–554 was intended to be used in such a manner. Therefore, in the May 9, 2002 proposed rule, we proposed to clarify existing policy that a previous 3-year reclassification may not be reinstated after a subsequent 3-year reclassification to another area takes effect. This means that a hospital that is reclassified to an area for purposes of the wage index may have only one active 3-year reclassification at a time. Once a 3-year reclassification to a second area becomes effective, a previously terminated 3-year reclassification may not be reinstated by terminating or withdrawing the reclassification to the second area and then canceling the termination or withdrawal of the reclassification to the first area.

As we stated in the August 1, 2001 final rule, we believe the 3-year wage index reclassification policy was intended to provide consistency and predictability in hospital reclassifications and the wage index. Allowing hospitals multiple reclassification options to choose from would create a situation where many hospitals move in unpredictable ways between the proposed and final rules based on their calculation of which of several areas would yield the highest wage index. This would reduce the predictability of the system, hampering the ability of the majority of hospitals to adequately project their future revenues. Therefore, in the May 9, 2002 proposed rule, we proposed to amend § 412.273(b)(2)(ii) to provide that, once a 3-year reclassification becomes effective, a hospital may no longer cancel a withdrawal or termination of another 3-year reclassification, even within 3 years from the date of such withdrawal or termination. We also proposed a technical correction to § 412.273(b)(2)(i) to correct the terminology regarding canceling (rather than terminating) a withdrawal.

Finally, the August 1, 2001 final rule did not specifically describe the process to cancel a withdrawal or termination. Therefore, in the May 9, 2002 proposed rule, we proposed to add a new § 412.273(d) (existing paragraph (d) would be redesignated as paragraph (e)) to describe the process whereby a hospital may cancel a previous withdrawal or termination of a 3-year wage index reclassification. Specifically, a hospital may cancel a previous withdrawal or termination by submitting written notice of its intent to the MGCRB no later than the deadline for submitting reclassification applications for reclassifications effective at the start of the following fiscal year (§ 412.256(a)(2)).

We did not receive any comments on these proposed changes. Therefore, in this final rule we are adopting the proposed changes as final.

2. Effect of Change of Ownership on Hospital Reclassifications

Sections 412.230(e)(2)(ii) and 412.232(d)(2)(ii) provide that, for reclassifications effective beginning FY 2003, a hospital must provide a weighted 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes.

As discussed in the August 1, 2001 final rule, we received a comment suggesting that, for purposes of calculating the 3-year average hourly wages, we permit a hospital that has changed ownership the option of excluding prior years' wage data submitted by a previous owner in order for the new hospital to qualify for reclassification. Although we responded to the comment in the August 1, 2001 final rule (66 FR 39890), we have now determined that there is a need to clarify further our policy regarding change of ownership and hospitals that do not accept assignment of the previous owner's provider agreement.

In our response to the comment, we stated that, where a hospital has changed ownership and the new owners have acquired the financial assets and liabilities of the previous owners, all of the applicable wage data associated with that hospital are included in the calculation of its 3-year average hourly wage. Where the new hospital does not claim the financial assets or assume the liabilities of a predecessor hospital, the wage data associated with the previous hospital's provider number would not be used in calculating the new hospital's 3-year average hourly wage.

Section 489.18(c) provides that, when there is a change of ownership, the existing provider agreement will automatically be assigned to the new owner when the parties agree to accept assignment of the provider agreement. Our regulations at § 412.230(e)(2) do not specifically address the situation of new hospitals seeking to reclassify for wage index purposes, in light of the requirement that reclassification is based on a 3-year average hourly wage. Therefore, as we proposed in the May 9, 2002 proposed rule, in this final rule we are revising § 412.230(e)(2), by adding a new paragraph (e)(2)(iii), to clarify our existing policy to specify that, in situations where a hospital does not accept assignment of the existing hospital's provider agreement under § 489.18, the hospital will be treated as a new hospital with a new provider number. In that case, the wage data associated with the previous hospital's provider number will not be used in calculating the new hospital's 3-year average hourly wage. As we stated in the August 1, 2001 final rule, we believe this policy clarification is consistent with how we treat hospitals whose ownership has changed for other Medicare payment purposes. Thus, we are revising § 412.230 to clarify, under new paragraph (e)(2)(iii), that once a new hospital has accumulated at least 1 year of wage data using survey data from the CMS hospital wage survey

used to determine the wage index, it is eligible to apply for reclassification on the basis of those data.

Comment: One commenter indicated that our efforts to clarify our policy regarding change of ownership create a financial incentive for new owners to go through the ''onerous and costly'' process of obtaining new provider numbers in order to obtain geographic reclassification. The commenter believed that any valid change in ownership under § 489.19 should allow a hospital the opportunity to request reclassification and that we should clarify that all payment areas impacted by the assignment of a new provider number should be consistently applied.

Response: This clarification establishes clear, predictable guidelines as to how hospitals' data will be treated for reclassification purposes. The rule was not adopted to govern provider behavior, since we cannot predict hospitals' behavior in situations where they may perceive it to be to their financial advantage to change their ownership arrangements. Rather, given the guidelines established by CMS, hospitals are free to act in their best interests.

I. Payment for Direct Costs of Graduate Medical Education (§ 413.86)

1. Background

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of graduate medical education (GME). The payments are based in part on the number of residents trained by the hospital. Section 1886(h) of the Act caps the number of residents that hospitals may count for direct GME.

Section 1886(h)(2) of the Act, as amended by section 9202 of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272), and implemented in regulations at § 413.86(e), establishes a methodology for determining payments to hospitals for the costs of approved GME programs. Section 1886(h)(2) of the Act, as amended by COBRA, sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983 through September 30, 1984). The PRA is multiplied by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (or nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payments. In addition, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning on or after October 1, 1993, through September 30, 1995, each hospital's PRA for the previous cost reporting period is not updated for inflation for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals with both primary care and obstetrics and gynecology residents and nonprimary care residents in FY 1994 or FY 1995 have two separate PRAs: one for primary care and obstetrics and gynecology and one for nonprimary care.

Section 1886(h)(2) of the Act was further amended by section 311 of Public Law 106–113 to establish a methodology for the use of a national average PRA in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000, and on or before September 30, 2005. Generally, section 1886(h)(2)(D) of the Act establishes a ''floor'' and a ''ceiling'' based on a locality-adjusted, updated, weighted average PRA. Each hospital's PRA is compared to the floor and ceiling to determine whether its PRA should be revised.For cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, the floor PRA is 70 percent of the locality-adjusted, updated, weighted average PRA. For cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002, section 511 of Public Law 106–554 amended the floor PRA to equal 85 percent of the locality-adjusted, updated, weighted average PRA. PRAs that are below the applicable floor PRA for a particular cost reporting period would be adjusted to equal the floor PRA. PRAs that exceed the ceiling, that is, 140 percent of the locality-adjusted, updated, weighted average PRA, would, depending on the fiscal year, either be frozen and not increased for inflation, or be increased by a reduced inflation factor. Existing regulations at § 413.86(e)(4) specify the methodology for calculating each hospital's weighted average PRA and the steps for determining whether a hospital's PRA will be revised.

2. Determining the Weighted Average PRAs for Newly Participating Hospitals (§ 413.86(e)(5))

As stated earlier, under section 1886(h) of the Act and implementing regulations, in most cases Medicare pays hospitals for the direct costs of GME on the basis of per resident costs in a 1984 base year. However, under existing § 413.86(e)(5), if a hospital did not have residents in an approved residency training program, or did not participate in Medicare during the base period, the hospital's base period for its PRA is its first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. There must be at least three existing teaching hospitals with PRAs in the MSA for this calculation.

If there are at least three existing teaching hospitals with PRAs in the same geographic wage area (MSA), as that term is used in 42 CFR Part 412, the fiscal intermediary will calculate a PRA based on the lower of the new teaching hospital's actual cost per resident in its base period or a weighted average of all the PRAs of existing teaching hospitals in the same MSA. If there are less than three existing teaching hospitals with PRAs within the new teaching hospital's MSA, effective for cost reporting periods beginning on or after October 1, 1997, the fiscal intermediary uses the updated regional weighted average PRA (determined for each of the nine census regions established by the Bureau of Census for statistical and reporting purposes) for the new teaching hospital's MSA (see 62 FR 46004, August 29, 1997). A new teaching hospital is assigned a PRA equal to the lower of its actual allowable direct GME costs per resident or the weighted average PRA as calculated by the fiscal intermediary. Using a methodology based on a weighted average ensures that a new teaching hospital receives a PRA that is representative of the costs of training residents within its specific geographic wage area.

Under existing policy, to calculate the weighted average PRA of teaching hospitals within a particular MSA, the fiscal intermediary begins by determining the base year PRA and the base year FTE count of each respective teaching hospital within that MSA. The weighted average PRA is (a) the sum of the products of each existing teaching hospital's base year PRA in the MSA and its base year FTEs, (b) divided by the sum of the base year FTEs from each of those hospitals. While a methodology using base year PRAs and FTEs was appropriate and workable in the years closely following the implementation of hospital—specific PRAs, it has become administratively burdensome for both CMS and the fiscal intermediaries to recreate base year information in calculating a weighted average. The methodology is particularly problematic in instances where there are large

numbers of teaching hospitals in an MSA.

In addition, as discussed in section V.I.1. of this final rule, hospitals that were training nonprimary care residents during FYs 1994 and 1995 have a distinct nonprimary care PRA, because there was no update in the inflation factor for these years (§ 413.86(e)(3)(ii)). Thus, most teaching hospitals currently have two PRAs: one for primary care and obstetrics and gynecology; and one for all other residents. (Hospitals that first train residents after FY 1995 only have a single PRA, regardless of whether they train primary care or other residents.) However, since the current methodology for calculating weighted average PRAs is based on data from FY 1984, which was prior to the years during which the PRAs were not adjusted for inflation to reflect nonprimary care residents, the methodology does not account for all PRAs (both primary care and obstetrics and gynecology and nonprimary care) within an MSA.

Accordingly, in the May 9, 2002 proposed rule, we proposed to simplify and revise the weighted average PRA methodology under § 413.86(e)(5)(i)(B) to reflect the average of all PRAs in an MSA, both primary care and obstetrics and gynecology, and nonprimary care. We proposed to continue to calculate a weighted average PRA. However, rather than using 1984 base year data, we proposed to use PRAs (both primary care and obstetrics and gynecology and nonprimary care) and FTE data from the most recently settled cost reports of teaching hospitals in an MSA. We proposed that the intermediary would calculate the weighted average PRA using the following steps:

Step 1: Identify all teaching hospitals (including those serviced by another intermediary(ies)) in the same MSA as the new teaching hospital.

Step 2: Identify the respective primary care and obstetrics and gynecology FTE counts, the nonprimary care FTE counts, or the total FTE count (for hospitals with a single PRA) of each teaching hospital in step 1 from the most recently settled cost reports. (Use the FTE counts from line 3.07, line 3.08, and line 3.11 of the Medicare cost report, CMS–2552–96,Worksheet E–3, Part IV.)

(We note that, under step 2, we have added ''line 3.11'' of the cost report to capture dental and podiatry FTE counts as part of the nonprimary care FTE counts. We made this addition in response to a comment received, as discussed below under the comment and response section for this area.)

Step 3: Identify the PRAs (either a hospital's primary care and obstetrics and gynecology PRA and nonprimary care PRA, or a hospital's single PRA) from the most recently settled cost reports of the hospitals in step 1, and update the PRAs using the CPI–U inflation factor to coincide with the fiscal year end of the new teaching hospital's base year cost reporting period. For example, if the base year fiscal year end of a new teaching hospital is December 31, 2003, and the most recently settled cost reports of the teaching hospitals within the MSA are from the fiscal years ending June 30, 2000, September 30, 2000, or December 31, 2000, the PRAs from these cost reports would be updated for inflation to December 31, 2003.

Step 4: Calculate the weighted average PRA using the PRAs and FTE counts from steps 2 and 3. For each hospital in the calculation:

(a) Multiply the primary care PRA by the primary care and obstetrics and gynecology FTEs.

(b) Multiply the nonprimary care PRA by the nonprimary care FTEs.

(c) For hospitals with a single PRA, multiply the single PRA by the hospital's total number of FTEs.

(d) Add the products from steps (a), (b), and (c) for all hospitals.

(e) Add the FTEs from step 3 for all hospitals.

(f) Divide the sum from step (d) by the sum from step (e). The result is the weighted average PRA for hospitals within an MSA.

The following is an example of how to calculate a weighted average PRA under this revised methodology:

Example

Assume that new Hospital A has a June 30 fiscal year end and begins training residents for the first time on July 1, 2003. Thus, new Hospital A's base year for purposes of establishing a PRA is the fiscal year ending June 30, 2004. New Hospital A is located in MSA 1234, in which three other teaching hospitals exist, Hospital B, Hospital C, and Hospital D. These three hospitals also have a fiscal year end of June 30 and their most recently settled cost reports are for the fiscal year ending June 30, 2000. For fiscal year ending June 30, 2000, Hospital B has 200 primary care and obstetrics and gynecology FTEs, 150 nonprimary care FTEs, and 150 nonprimary care FTEs. Hospital C has 50 primary care and obstetrics and gynecology FTEs and 60 nonprimary care FTEs. Hospital D has 25 FTEs. After updating the PRAs for inflation by the CPI–U to June 30, 2004, Hospital B has a primary care and obstetrics and gynecology PRA of $120,000 and a nonprimary care PRA of $115,000, Hospital C has a primary care and obstetrics and gynecology PRA of $100,000 and a nonprimary care PRA of $97,000, and Hospital D has a single PRA of $90,000.

(a) Primary care:
Hospital B: $120,000 × 200 FTEs = $24,000,000
Hospital C: $100,000 × 50 FTEs = $5,000,000

(b) Nonprimary care:
Hospital B: $115,000 × 150 FTEs = $17,250,000
Hospital C: $97,000 × 60 FTEs = $5,820,000

(c) Single PRA:
Hospital D: $90,000 x 25 FTEs =$2,250,000

(d) $24,000,000 + 5,000,000 + $17,250,000 + $5,820,000 + $2,250,000 = $54,320,000.

(e) 200 + 50 + 150 + 60 + 25 = 485 total FTEs.

(f) $54,320,000/485FTEs = $112,000, the weighted average PRA for MSA 1234 for fiscal year ending June 30,2004.

New Hospital A's PRA would be the lower of $112,000 or its actual base year GME costs per resident.

In the May 9, 2002 proposed rule, we proposed that the new weighted average calculation would be effective for hospitals with direct GME base years that begin on or after October 1, 2002.

In addition, we are taking the opportunity to clarify the language under existing § 413.86(e)(5)(i)(B), which relates to calculating the weighted average under existing policy. Specifically, existing § 413.86(e)(5)(i)(B) states: ''The weighted mean value of per resident amounts of all hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter, *for cost reporting periods beginning in the same fiscal years* [emphasis added].'' We believe this language could be misinterpreted to imply that only those PRAs of hospitals in the same geographic wage area (MSA) *that have the same fiscal year end as the new teaching hospital* should be used in the weighted average calculation. However, the PRAs of *all* hospitals within the MSA of the new teaching hospital should be used, not just the PRAs of hospitals with the same fiscal year end as the new teaching hospital. We proposed a revision under a proposed new § 413.86(e)(5)(i)(C).

Comment: One commenter expressed concern about our proposed changes to the calculation of weighted average PRAs for new teaching hospitals. The

commenter believed that our proposed methodology is as administratively burdensome as the existing methodology, because the servicing intermediary would be required to solicit most recently settled cost report data from all other intermediaries servicing providers in the defined territory every time a new PRA needs to be calculated. As an alternative to using most recently settled cost report data, the commenter suggested that we specify a cost reporting period from which all future data can be updated (that is, cost reporting periods ending between October 1, 1998 and September 30, 1999). The commenter indicated that it would be helpful if we would provide all intermediaries with a nationwide listing of all teaching hospitals (extracted from the HCRIS and compiled in a database/spreadsheet format), including provider number, MSA number, county, PRAs, and primary and nonprimary care FTE counts from the specified cost reporting period.

Response: We understand the commenter's concerns, but we believe that using data from most recently settled cost reports results in a weighted average PRA that more appropriately reflects the pertinent dynamics of residency training in a specific geographical area. We note that the requirement to use data from all hospitals in an MSA, regardless of whether they are serviced by different intermediaries, exists even under current regulations. In addition, generally, hospitals in the same MSA either use the same fiscal intermediary or one of two fiscal intermediaries and, therefore, we do not believe that it is unreasonably difficult to obtain information from another intermediary. Furthermore, as we have done in the past, we will continue to provide assistance to the intermediaries involved in the process of calculating the weighted average PRAs. Finally, we will consider the commenter's suggestion concerning the compilation of a nationwide database.

Comment: One commenter asked whether, considering that dental and podiatry residents are also nonprimary care, the FTE count of dental and podiatry residents from line 3.11 of worksheet E–3 Part IV should be included in determining the FTE counts in step 2 of the calculation in the proposed rule (67 FR 31467).

Response: Step 2 of the proposed calculation states, ''Identify the respective primary care and obstetrics and gynecology FTE counts, the nonprimary care FTE counts, or the total FTE count (for hospitals with a single PRA) of each teaching hospital in step 1 from the most recently settled cost reports. (Use the FTE counts from line 3.07 and line 3.08 of the Medicare cost report, CMS–2552–96, Worksheet E–3, Part IV).'' We agree with the commenter that the dental and podiatry FTE counts should also be included, and, therefore, we are revising step 2 in the example in this final rule to state that intermediaries should use the FTE counts from line 3.07, line 3.08, and line 3.11 of the Medicare cost report.

Accordingly, in this final rule, we are adopting as final the proposed revised § 413.86(e)(5)(i)(B) and the proposed new § 413.86(e)(5)(i)(C) without modification.

3. Aggregate FTE Limit for Affiliated Groups (§§ 413.86(b) and (g)(7))

Section 1886(h)(4)(H)(ii) of the Act permits, but does not require, the Secretary to prescribe rules that allow institutions that are members of the same affiliated group (as defined by the Secretary) to elect to apply the FTE resident limit on an aggregate basis. This provision allows the Secretary to permit hospitals flexibility in structuring rotations within a combined cap when they share residents' time. Consistent with the broad authority conferred by the statute, we established criteria for defining an ''affiliated group'' and an ''affiliation agreement'' in both the August 29, 1997 final rule (62 FR 45965) and the May 12, 1998 final rule (63 FR 26317). Because we had received many inquiries from the hospital industry on this policy, we proposed in the May 9, 2002 proposed rule to clarify in regulations the requirements for participating in an affiliated group. Most of these requirements are explicitly derived from the policy explained in the August 29, 1997 and May 12, 1998 final rules.

Specifically, we proposed to add under § 413.86(b) a new definition of ''Affiliation agreement.'' Under this new definition, we proposed to specify that an affiliation agreement is a written, signed, and dated agreement by responsible representatives of each respective hospital in an affiliated group (as defined in § 413.86(b)), that specifies—

- The term of the agreement, which, at a minimum must be one year, beginning on July 1 of a year.
- Each participating hospital's direct and indirect FTE cap.
- The annual adjustment to each hospital's FTE caps, for both direct GME and IME. This adjustment must reflect the fact that any positive adjustment to one hospital's direct and indirect FTE caps must be offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount.
- The names of the participating hospitals and their Medicare provider numbers.

In addition, we proposed to add a new § 413.86(g)(5)(iv) and a new § 413.86(g)(7) to clarify the requirements for a hospital to receive a temporary adjustment to its FTE cap through an affiliation agreement. (Existing § 413.86(g)(5)(iv) through (vi) were proposed to be redesignated as § 413.86(g)(5)(v) through (vii), respectively; and existing §§ 413.86(g)(7) through (g)(12) were proposed to be redesignated as §§ 413.86(g)(8) through (g)(13), respectively, to accommodate these additions.) Specifically, we proposed that a hospital may receive a temporary adjustment to its FTE cap, which is subject to the averaging rules, to reflect residents added or subtracted because the hospital is participating in an affiliated group (as that term is defined under § 413.86(b)). Under the proposed provision—

- Each hospital in the affiliated group must submit the affiliation agreement (as that term is proposed to be defined under § 413.86(b)), to the CMS fiscal intermediary servicing the hospital and send a copy to CMS's Central Office no later than July 1 of the residency program year during which the affiliation agreement will be in effect.
- There must be a rotation of a resident(s) among the hospitals participating in the affiliated group during the term of the affiliation agreement, such that more than one of the hospitals counts the proportionate amount of the time spent by the resident(s) in their FTE resident counts. (However, no resident may be counted in the aggregate as more than one FTE.) This requirement is intended to ensure that the participating hospitals maintain a ''cross-training'' relationship during the term of the affiliation agreement.
- The net effect of the adjustments (positive or negative) on the affiliated hospitals' aggregate FTE cap for each affiliation agreement must not exceed zero.
- If the affiliation agreement terminates for any reason, the FTE cap for each hospital in the affiliated group will revert to the individual hospital's pre-affiliation FTE cap.

Except for the proposed new § 413.86(g)(7)(iv) regarding the treatment of FTE caps after termination of the affiliation agreement, each provision of proposed new § 413.86(g)(7) was explicitly derived from policy stated in the May 12, 1998 final rule (63 FR 26336). We proposed

to incorporate in regulations policy that was previously established under the formal rulemaking process.

We proposed a change in policy concerning what happens to each participating affiliated hospital's FTE cap when an affiliation agreement terminates (proposed new § 413.86(g)(7)(iv)). In the preamble of the May 12, 1998 final rule (63 FR 26339), we stated: ''Each agreement must also specify the adjustment to each respective hospital cap in the event the agreement terminates, dissolves, or, if the agreement is for a specified time period, for residency training years and cost reporting periods subsequent to the period of the agreement for purposes of applying the FTE cap on an aggregate basis. In the absence of an agreement on the FTE caps for each respective institution following the end of the agreement, each hospital's FTE cap will be the indirect and direct medical education FTE count from each hospital's cost reporting period ending in 1996 and the cap will not be applied on an aggregate basis.'' Our purpose for allowing hospitals to redistribute their FTE caps (within the limits of the aggregate FTE caps) upon the termination of an affiliation was to enable hospitals by agreement to more closely reflect the realities of the residency rotational arrangement. However, in practice, very few hospitals have altered their FTE caps following termination of affiliation agreements. Rather, in virtually every agreement, hospitals opted to revert to their respective 1996 FTE caps upon the termination of an affiliation. In addition, we have found that our existing policy is susceptible to abusive practices that do not comport with our original purpose for allowing redistribution of FTE caps among hospitals following termination of an affiliation agreement. We have learned of a number of instances in which one hospital (Hospital A) affiliated with another hospital (Hospital B) in anticipation of Hospital B's closure at some point during the residency program year. In these instances, the affiliation agreement was made solely for the purpose of obtaining a permanent adjustment to Hospital A's FTE cap through the terms of the termination clause. As we explained in the preamble to the May 9, 2002 proposed rule, we do not believe these permanent FTE cap adjustments that result from hospital closures (or any other circumstances) were intended when Congress passed the provision on affiliation agreements. As stated above, we believe affiliations were meant to provide flexibility for hospitals in the rotations of residents where, in the normal course of an affiliation between two or more hospitals, the actual number of residents training at each hospital may vary somewhat from year to year. Affiliations were not intended to be used as a vehicle for circumventing the statutory hospital-specific FTE cap on the number of residents. In addition, we have separately addressed issues that arise when residents are displaced because of a hospital closure. We have in place a policy at existing § 413.86(g)(8) (which was proposed to be redesignated as § 413.86(g)(9) in the May 9, 2002 proposed rule) that permits temporary FTE cap adjustments for hospitals that take on the training of residents displaced by the closure of another hospital.

Therefore, in the May 9, 2002 proposed rule, we proposed that, effective October 1, 2002, for hospitals with affiliation agreements that terminate (for any reason) on or after that date, the direct and indirect FTE caps for each hospital in the affiliated group will revert back to each individual hospital's original FTE cap prior to the affiliation (proposed new § 413.86(g)(7)(iv)). This policy would not preclude the participating hospitals from entering into additional affiliation agreements for later residency years.

Since the proposed policy would be effective for agreements that terminate on or after October 1, 2002, hospitals that have already received a permanent FTE cap adjustment from their fiscal intermediaries through the existing termination clause policy would retain those cap adjustments.

We also proposed to make a conforming clarification at § 412.105(f)(1)(vi) for purposes of IME payments.

Definition of ''Affiliation Agreement'' and the Requirements at Revised § 413.86(g)(7)

Comment: Several commenters were concerned about our requirement at proposed § 413.86(b) in the definition of ''affiliation agreement'' that the agreement specify FTE cap adjustments based on a 12-month period that begins July 1 and ends June 30. Many commenters believed that the requirement should be changed so that hospitals may execute affiliation agreements at any time during the year. One commenter believed that since, regardless of the date it is executed, the resident count set forth in the agreement must be reconciled with the hospital's cost reporting period, permitting hospitals to execute agreements throughout the year would reduce the hospital's administrative burdens without imposing much, if any, additional hardship on Medicare program administration. Another commenter suggested that CMS could delay the filing date for affiliations from July 1 until either the first day of a hospital's next cost reporting period beginning after commencement of the July 1 residency period, or October 1, whichever time period is longer.

Response: We set a July 1 deadline for submission of affiliation agreements (proposed § 413.86(g)(7)(i)), as well as specifications of FTE cap adjustments in the affiliation agreements, based on the July 1 residency training year because we believed that choosing one date was administratively less burdensome to our fiscal intermediaries for purposes of audit of the participating hospitals' Medicare cost reports. In addition, we chose July 1 because we believe that date is the start date of virtually all residency training programs across all specialties. We would be more sympathetic to the commenters' request for changes in the execution date if we had heard of residency training programs that begin on dates other than July 1. Until we hear of specific programs that begin on other than July 1, we continue to believe that it is appropriate and consistent with efficient administration of the Medicare program to maintain the existing policy based on the July 1 residency training program year. We believe that it is not only less burdensome for our fiscal intermediaries (as well as CMS) to receive affiliation agreements at one point in the year alone, but we also believe it is less burdensome to participating hospitals. We believe that the vast majority of participating hospitals will know prior to July 1 how many residents will be training at the hospital in any given residency program year and how many residents would be rotating in from other hospitals.

Comment: One hospital commenter described a situation in which its existing affiliation agreement with another hospital, which was submitted to the fiscal intermediary with a copy to CMS (at that time HCFA) Central Office on July 1, 1998, states that the affiliation agreement ''shall continue in effect on an indefinite basis until terminated by the agreement of all Hospitals * * * of the affiliated group.'' The commenter asked us whether this term language meets the requirements in the proposed rule.

The same commenter mentioned that its affiliation agreement from 1998 does not specify each participating hospital's direct and indirect FTE cap, ''as this was not required in the August 29, 1997,

and May 12, 1998 final rules.'' In addition, the commenter asked whether changes in a hospital's FTE caps can be accounted for under the proposed rule. Finally, the commenter asked whether documents other than the affiliation agreement, such as attachments to the affiliation agreement, can be used to identify a hospital's direct and indirect FTE caps.

Response: As we proposed at § 413.86(b), each affiliation agreement should specify the term of the agreement ''which at a minimum is one year,'' beginning on July 1 of a year. We stated similarly in the May 12, 1998 final rule on affiliation agreements (63 FR 26341) that ''each agreement must be for a minimum of one year.'' However, there is nothing to prohibit affiliation agreements from being automatically renewable each year or from being for terms greater than one year in length. Therefore, the language that the commenter apparently used in its affiliation agreement would meet existing Medicare policy on affiliation agreements and their effectiveness. As long as the affiliation agreements cover a period of time of at least one year beginning July 1 of a year, the affiliation agreements meet the term requirement at § 413.86(b).

To address the commenter's statement that it did not report the direct and indirect GME FTE caps for the participating hospitals in its affiliation agreement because it was not previously required to do so, we stated clearly in the May 12, 1998 interim final rule that hospitals must specify the ''planned changes to individual hospital counts under an aggregate FTE cap'' (63 FR 26341). Although, under existing policy, hospitals might have reported ''planned changes'' to FTE caps in a number of ways, there is no question that they were required to do so. The revised requirements at § 413.86(b) specify that the hospital must include in the affiliation agreement each participating hospital's direct and indirect GME FTE caps in effect prior to the affiliation. The reason for requiring that affiliation agreements specify the direct and indirect FTE caps for participating hospitals is so that all hospitals will report the ''planned changes'' in the same way, allowing for ease of administration for CMS and fiscal intermediaries.

We also understand that some hospitals qualify for other FTE cap adjustments, such as those for new programs under § 413.86(g)(6)(ii). Hospitals would report their most current FTE caps in effect in the period immediately prior to the effective date of the affiliation for both direct GME and indirect medical education, so that the caps are reflective of the other FTE cap adjustments.

To respond to the commenter's question about whether attached documents to the affiliation agreement will suffice to identify direct and indirect GME FTE caps, we believe attached documents would be adequate, so long as they are considered part of the overall package of the affiliation agreement. We have stated repeatedly to the provider community that affiliation agreements need *not* be lengthy documents. In the past, we have received affiliation agreements that range in length from 2 pages to 30 pages. Each type of agreement (short or long) would be adequate as long as the affiliation agreement meets the provisions under proposed § 413.86(b).

Comment: One commenter asked how the proposed rule contemplates handling changes in the hospital's FTE adjustments if actual rotations in a given residency year turn out differently than what was stated in the affiliation agreement at the start of the residency year on July 1.

Response: We stated in the May 12, 1998 final rule (63 FR 26339) that the hospitals in the affiliated group may submit modifications to the initially reported distribution of the aggregate FTE count by June 30 of the current residency training year, if actual FTE counts for the program year are different than projected in the original agreement. While modifications to the original distribution of the aggregate FTE cap are permitted in order to allow for some fluctuations based on the actual placement of those residents within the affiliated hospitals, the overall affiliation agreement cannot be modified (for example, by adding other hospitals to increase the original aggregate cap). In most cases, we expect that the modifications to the affiliation agreements, which should be signed by all participating hospitals and submitted to the fiscal intermediary, will reflect the realities of what actually occurred as far as the number of residents that rotated in and out of each hospital during the program year. Accordingly, we would be skeptical of modifications that deviate significantly from the original affiliation agreement.

Comment: One commenter that suggested a technical change in the terminology for affiliation agreements to ''resident limit aggregation agreements'' or ''aggregation agreements.'' The commenter believed that ''affiliation agreement'' historically is a term of art in the academic community and generally relates to agreements made between hospitals and medical schools or among sponsors of medical residency education programs.

Response: We are aware that there has been some confusion at times among members of the provider community when using the term ''affiliation agreement,'' and we recognize that the term is utilized in contexts other than in the Medicare usage of the term for GME payment. However, we believe the Medicare use of the term is an appropriate one, rather than ''aggregation agreement'' or ''resident limit aggregation agreement.'' We note that section 1886(h)(4)(H)(ii) of the Act uses the term ''affiliated group'' and contemplates that the Secretary will define that term. Further, as we stated above, the point of the policy is that there are ''affiliations'' among the participating hospitals; that is, rotations of residents among the hospitals for purposes of applying the Medicare FTE caps. Therefore, we are not adopting the commenter's suggested technical change.

Cross-Training Requirement

Comment: Numerous commenters inquired about or addressed our proposal at § 413.86(g)(7)(ii) to clarify in regulations the requirement of a rotation of residents among the hospitals participating in every affiliated group. One commenter agreed that this requirement is appropriate in regard to nonrelated hospitals that join together in an affiliation agreement, since the cross-training is the only basis for the affiliation. However, the commenter believed it should not be applied to affiliation agreements involving only commonly owned or related hospitals because commonly owned hospitals in an affiliated group are already held to the aggregate resident cap. The commenter believed it is unnecessary and burdensome to add a further requirement that each hospital participate in a rotation to other hospitals in order to be included as part of the affiliated group.

Another commenter disagreed that this provision on cross-training between all hospitals in an affiliated group joined by common ownership is a clarification instead of a new rule. Consequently, this commenter believed the implementation of the cross-training provision should be prospective and deferred to become effective with affiliations beginning July 1, 2003. The commenter stated that if its proposal is not accepted, hospitals not in compliance should be given an opportunity to file a new affiliation agreement rather than forfeit the ability to affiliate altogether for the 2002–2003 period.

Response: We disagree with the commenter's statement that commonly owned hospitals in an affiliated group are ''already'' held to the aggregate resident cap. Hospitals are only held to an aggregate resident cap through the act of entering into a Medicare affiliation agreement, and a Medicare affiliation is not valid without the existence of a cross-training relationship. Our proposal to add an explicit cross-training requirement at § 413.86(g)(7)(ii) resulted from our belief that all hospitals that affiliate, regardless of the criteria under which they qualify to affiliate, should meet the cross-training requirement. The intent of affiliated groups is to provide flexibility within the FTE caps to hospitals that have a rotational relationship; affiliated groups are not meant to serve as a mechanism for circumventing the FTE caps. However, we acknowledge that the existing definition of ''affiliated group'' at § 413.86(b) is silent with respect to whether the cross-training requirement applies to hospitals that affiliated based on the common ownership criterion.

Nevertheless, we emphasize that the proposed cross-training requirement is derived from a broad-based cross-training policy expressed in previous final rules applying to all affiliated groups, including hospitals affiliated under common ownership. Specifically, in the May 12, 1998 final rule (63 FR 26336) we state, ''The criteria we established to determine whether two or more hospitals qualify to be an affiliated group were designed to identify hospitals that have relationships for training residents and to allow those hospitals to continue to have the flexibility to rotate residents under an aggregate FTE cap.'' Further, we initially amended the definition of an affiliated group at § 413.86(b) (63 FR 26337) to include hospitals under common ownership in response to a commenter's statement that hospitals under a single health care system ''* * * functionally operate coordinated and centrally controlled GME programs and often *rotate their residents among their various facilities* depending on training needs and other considerations'' (emphasis added). Finally, we state, ''A hospital will be permitted to engage in multiple agreements with different hospitals, as illustrated below. For example, hospital A can have an agreement with hospital B for an internal medicine program and another agreement with hospital C for emergency medicine. Although hospitals B and C do not have an agreement for any program, the affiliated group is A, B, and C; that is, the FTE resident counts at hospitals A, B, and C cannot exceed the sum of the combined caps for the three hospitals'' (63 FR 26338–26339).

Therefore, to be consistent with the cross-training requirement we proposed at § 413.86(g)(7)(ii), we are adding a reference to the cross-training requirement in paragraph (3) of the definition of ''affiliated group'' under § 413.86(b). However, because our existing definition of affiliated group did not explicitly state the cross-training requirement for hospitals that affiliate based on common ownership, we recognize that our policy may have been subject to misinterpretation. Therefore, we are making this cross-training requirement for hospitals under common ownership effective for affiliation agreements beginning July 1, 2003, the date of the first training year beginning after publication of the final regulation. Accordingly, hospitals that have affiliated under the common ownership criterion but have not met, or currently are not meeting, the rotational requirement are not required to meet the cross-training requirement until July 1, 2003.

We also address the application of the cross-training requirement at § 413.86(g)(7)(ii) to the other bases for affiliation listed in the definition of ''affiliated group'' at existing regulations at § 413.86(b). Concerning hospitals located in the same urban or rural area or in contiguous areas, we believe that application of the cross-training requirement is explicit in existing policy and not a change. We believe that the existing regulations clearly express the cross-training requirement that residents must rotate among hospitals within the affiliated group during the course of the program. Paragraph (1) of the existing definition states that hospitals may qualify as an affiliated group if the hospitals are in the same urban or rural area or in contiguous areas, and ''if individual residents work at each of the hospitals during the course of the program.'' However, to maintain consistency, we are revising the language under paragraph (1) of the definition of an ''affiliated group'' to reference the new cross-training language at § 413.86(g)(7)(ii).

The language in paragraph (2) of the existing definition of ''affiliated group'' comes from the May 12, 1998 final rule (63 FR 26358). When we issued this language at existing paragraph (2) regarding affiliations of hospitals that are jointly listed as the sponsor of a program, we did not explicitly restate the cross-training requirement because it was assumed that these hospitals, by virtue of joint sponsorship, already meet the cross-training requirement. However, to be consistent, and to further emphasize that the cross-training requirement applies to *all* affiliating hospitals, we are also adding an explicit cross-training requirement at paragraph (2) in the definition of ''affiliated group'' under § 413.86(b) by referencing § 413.86(g)(7)(ii).

Comment: One commenter stated that our requirement concerning the cross-training of residents within an affiliated group is unwarranted due to the establishment of a single FTE cap for each hospital, rather than program-specific FTE caps for each hospital. The commenter contended that hospitals that agree to affiliate should be allowed to manage training of residents in a manner that ensures the most appropriate training is received, even if this means that there is no cross-training of residents. The commenter included the following example:

AB Health system operates a pediatrics program and a geriatrics program in two hospitals, A and B. Individual hospital 1996 FTE caps were established at 10 FTEs for Hospital A and 10 FTEs for Hospital B. Historically, residents in both programs rotated between both hospitals. In 2002, the programs were reorganized so that Hospital A now specializes in pediatrics and Hospital B now specializes in geriatrics, and as a result, the hospitals no longer cross-train residents. Hospital A currently trains 12 pediatric FTEs and Hospital B currently trains 8 geriatric FTEs.

The commenter explained that the cross-training requirement would effectively reduce the number of residents Medicare will recognize AB Health System in 2002 by 2 FTEs less than the number in 1996. The commenter asserted that, accordingly, the cross-training requirement is inconsistent with our establishment of one overall FTE cap per hospital.

Response: As we stated above, the provision for affiliated groups was included by Congress to accommodate hospitals that have an existing rotational relationship. It was understood that because of the movement of residents between hospitals, the number of residents at each hospital could vary each year. Therefore, because of these existing rotational arrangements, Congress intended to allow hospitals to aggregate and modify the FTE caps on a temporary basis. We do not believe it is appropriate to allow hospitals that do not have a rotational relationship to aggregate their FTE caps simply as a means of maximizing their Medicare reimbursement. However, we note, as we have stated above, hospitals that

affiliate under the common ownership criteria do not have to meet the cross-training requirement until July 1, 2003.

We emphasize again that the cross-training requirement for affiliations is not a new concept in policy regarding Medicare affiliated groups. Indeed, the May 12, 1998 final rule repeatedly stated the idea that the policy was established in order to ''allow those hospitals to continue to have the flexibility to rotate residents under an aggregate FTE cap'' (63 FR 26336). However, because much confusion or concern has been expressed in numerous inquiries and among several commenters about the proposed clarification of the cross-training requirement, particularly when it relates to the common ownership scenario, we are amending our regulations to further specify how the cross-training requirement will be applied in each of the scenarios for affiliated groups, including common ownership. Specifically, we are revising § 413.86(g)(7)(ii) to read as follows:

Each hospital in the affiliated group must have a shared rotational arrangement, as defined in § 413.86(b), with at least one other hospital within the affiliated group, and all the hospitals within the affiliated group must be connected by a series of such shared rotational arrangements.

We are specifying here and also at § 413.86(b) that ''shared rotational arrangement'' means a residency training program under which a resident(s) participates in training at two or more hospitals in that program. If residents rotate from one hospital to another at some point during the period of years required to complete training in a particular program, those hospitals have a ''shared rotational arrangement.'' In addition, all the hospitals within the affiliated group must be connected by a series of shared rotational arrangements. In other words, in order for the cross-training requirement to be met, there must be, at a minimum, a ''chain'' of rotations occurring from one hospital to the next within the affiliated group. For example, assume Hospitals A, B, C, and D form an affiliated group. Hospital A and Hospital B both train residents in an internal medicine program. In addition, Hospital B trains surgery residents, who also spend time training at Hospital C. Hospital C and Hospital D both operate an anesthesiology program and anesthesiology residents train in both Hospital C and Hospital D. Thus, Hospitals A and B, Hospitals B and C, and Hospitals C and D are connected by a series of shared rotational arrangements. This arrangement meets the cross-training requirement. All hospitals do not have to cross-train residents; this means that Hospital A does not have to send residents to Hospital B, Hospital C, and Hospital D, nor does Hospital B have to send residents to Hospital A, Hospital C, and Hospital D, nor does Hospital C have to send residents to Hospital A, Hospital B, and Hospital D, etc. A continuous linear chain is sufficient.

In another example of a ''shared rotational arrangement,'' Hospital A and Hospital B affiliate and they both offer training in family practice. If, at some point during the 3 years required to complete the family practice program, residents rotate from either Hospital A to Hospital B, Hospital B to Hospital A, or back and forth between Hospital A and Hospital B, then Hospital A and Hospital B have a ''shared rotational arrangement.'' Hospitals A and B may meet the definition of a ''shared rotational arrangement'' by rotating residents for a portion of a particular program year (PGY), or by rotating residents for an entire program year, so long as the family practice residents spend time at both hospitals to complete their training in family practice. For example, family practice residents may spend 3 months of their PGY1 at Hospital A and 9 months at Hospital B, or, the residents may spend their entire PGY1 training at Hospital A, and spend their entire PGY2 and PGY3 training at Hospital B. In either case, Hospital A and Hospital B have a shared rotational arrangement because they rotate residents over the course of a common training program.

Following are some examples of arrangements that do not meet the cross-training requirement:

- Hospitals A and B train residents at their respective hospitals but do not rotate residents between the 2 hospitals.
- Hospitals A, B, and C attest that they are aggregating their FTE caps, but only Hospitals A and B actually rotate residents between them, while Hospital C does not rotate residents to either Hospital A or Hospital B. In this scenario, Hospitals A and B may qualify as an affiliated group, but Hospital C may not be included for purposes of aggregating its FTE cap with Hospitals A and B, because Hospital C does not rotate residents with either Hospital A or Hospital B. Thus, Hospital C breaks the ''chain''; Hospital C is not connected to the other hospitals by a series of shared rotational arrangements.
- Hospitals A, B, C, and D attempt to aggregate their FTE caps. Hospitals A and B rotate residents between them, and Hospitals C and D rotate residents between them. In this scenario, Hospitals A and B may qualify as an affiliated group, and Hospitals C and D may qualify as a second affiliated group, but Hospitals A, B, C, and D may not qualify as a single affiliated group because the ''chain'' is broken by the lack of a series of shared rotational arrangements between Hospitals A or B and Hospitals C or D.

Finally, we believe that our regulations would be more consistent if we also amended the proposed definition of ''affiliation agreement'' at § 413.86(b) to require participating hospitals to specify the adjustment to each hospital's FTE counts resulting from the FTE resident's (or residents') participation in the shared rotational arrangement(s) at each hospital participating in the affiliated group for each year the affiliation agreement is in effect. We are also stating under this section that this adjustment to each participating hospital's FTE count is reflected in the total adjustments to each hospital's FTE caps under paragraph (3) of the definition for ''affiliation agreement'' at § 413.86(b). We believe this additional information will assist the fiscal intermediaries in tracking the FTE residents and ensuring that cross-training occurs in at least one program at each of the hospitals participating in the affiliated group, in accordance with the rotation requirement under revised proposed § 413.86(g)(7)(ii).

Example: Assume Hospital A has a direct GME FTE cap of 30 FTEs and an IME FTE cap of 29 FTEs. In the 2003–2004 residency year, Hospital A has an internal medicine residency program with 6 FTE residents training at Hospital A in each program year (a total of 18 FTEs). Hospital A also has a surgery residency program with 3 FTE residents training at Hospital A in each program year (a total of 9 FTEs). Note that Hospital A is not at its FTE cap for direct GME (there are 3 empty FTE slots) or IME (there are 2 empty FTE slots) in this fiscal year. Hospital A decides to rotate some of its residents over to Hospital B, which has an FTE cap of 5 FTEs for both direct GME and IME. Hospital B also rotates residents in a pediatric program to Hospital C. Hospital C has a direct GME cap of 9.5, and an IME cap of 10. The three hospitals affiliate to form an aggregate cap of 44.5 FTEs for direct GME and an aggregate cap of 44 FTEs for IME. Hospital A rotates 3 internal medicine FTEs and 1.5 surgery FTEs to Hospital B, for both direct GME and IME (for Hospitals A and B, this would be ''the adjustment to each participating hospital's FTE counts resulting from the FTE resident's (or residents') participation in the shared rotational arrangement(s) at each hospital

participating in the affiliated group''). In addition, Hospital A also moves more of its FTE cap to Hospital B: an additional 3 FTEs for direct GME and 2 FTEs for IME (as noted above, these FTEs were available in Hospital A's caps), because Hospital B would like to train more residents in other specialties than can be accommodated under its own cap of 5 FTEs. Hospital B sends 0.5 FTE for GME and 1 FTE for IME to Hospital C. These produce a net decrease to Hospital A's direct GME cap of 7.5 FTEs (to equal an adjusted cap of 22.5 for direct GME) and a net decrease to its IME cap of 6.5 FTEs (to equal an adjusted cap of 22.5 for IME). The net increase to Hospital B's direct GME cap is 7.0 (to equal an adjusted cap of 12.0 FTEs for direct GME) and a net increase to its IME cap of 5.5 FTEs (to equal an adjusted cap of 10.5 FTEs for IME). The net increase to Hospital C's direct GME cap is 0.5 (to equal an adjusted cap of 10 FTEs for direct GME and the net increase to its IME cap is 1.0 FTEs (to equal an adjusted cap of 11 FTEs for IME).

Accordingly, the requirements as specified under paragraphs (2), (3), and (4) of the definition of ''affiliation agreement'' at § 413.86(b) may be met if affiliation agreements give the following information (although it may be stated in narrative form, as above), using the information for Hospitals A and B and C above:

DIRECT GRADUATE MEDICAL EDUCATION

[FTE caps]

	FTE cap	Total cap adjustment	Revised caps
Hospital A	30	-7.5	22.5
Hospital B	5	7	12
Hospital C	9.5	0.5	10
Aggregate Cap	44.5	.....	44.5

SHARED ROTATIONAL ARRANGEMENT

	Minus	Plus
Hospital A	-4.5	.....
Hospital B	-0.5	4.5
Hospital C	.....	0.5

INDIRECT MEDICAL EDUCATION

[FTE caps]

	FTE cap	Total cap adjustment	Revised caps
Hospital A	29	-6.5	22.5
Hospital B	5	5.5	10.5
Hospital C	10	1	11
Aggregate Cap	44	.....	44

SHARED ROTATIONAL ARRANGEMENT

	Minus	Plus
Hospital A	-4.5	.....
Hospital B	-1	4.5
Hospital C	.....	1

Thus, while the respective hospitals aggregate their FTE caps as a whole, and list the upward and downward adjustments to the participating hospitals' direct and indirect FTE caps, under revised paragraph (3) of the definition of ''affiliation agreement'' under § 413.86(b), the affiliation agreement must now separately list the positive and negative adjustment to each participating hospital's FTE counts resulting from the FTE resident's (or residents') participation in the shared rotational arrangement(s) at each hospital participating in the affiliated group for each year the affiliation agreement is in effect (this may be different than the total effect of the affiliation on the hospital's cap).

In this final rule, we also are modifying § 413.86(g)(7) to add a new paragraph (iii) to state that, in accordance with proposed § 413.86(g)(7)(ii), during the shared rotational arrangements in the affiliation, more than one of the hospitals in the affiliated group must count the proportionate amount of the time spent by the resident(s) in their FTE resident counts, and that no resident may be counted in the aggregate as more than one FTE.

The Termination Clause

We received numerous comments concerning our proposed policy change on the effect of an affiliation termination on each participating hospital's FTE cap. We proposed that, upon termination of an affiliation, each affiliated hospital will revert back to its original FTE caps for both direct GME and IME prior to the affiliation. Many commenters urged us to reconsider the proposal and to keep the existing policy allowing for FTE cap redistribution upon affiliation termination.

Comment: Several commenters noted the Conference Report accompanying the Balanced Budget Act of 1997 (BBA) which stated that while CMS was given flexibility in implementing the resident limits, the flexibility is ''limited by the conference agreement that the aggregate number of FTE residents should not increase over current levels.'' (H.R. Conference Report, Rept. No. 105–217, 105th Cong., 1st Sess., 1997, pp. 821–822). One commenter stated that they believe the Conference Report makes clear that the conferees understood that ''a sizeable number of hospitals elect to initiate 'as well as terminate' medical education programs over a period of time,'' and that the Conferees were ''concerned that within the principles of the cap * * * there is proper flexibility to respond to such changing needs * * *.'' These commenters believe that our policy change would therefore be contrary to Congress' wishes.

Response: As we explain above, and also in the proposed rule, existing policy allows affiliated hospitals to redistribute their FTE caps (within the limits of the aggregate FTE caps) upon the termination of the affiliation agreement in order to enable hospitals by agreement to more closely reflect the realities of the residency rotational arrangement. However, we proposed to change this policy because we believed it was susceptible to abusive practices such as the formation of affiliation agreements solely for the purpose of obtaining permanent adjustments to FTE caps. In fact, the commenters who advocated retaining the existing policy argued that this provision is needed to allow hospitals to increase their caps, when another hospital closes.

To address the commenters' belief that our proposed change is contrary to Congressional wishes, we note that the language quoted above from the Conference Agreement accompanying the BBA that the commenters use to support that assertion was actually intended to address Congress' newly enacted policy in the BBA on new residency program adjustments (see section 1886(h)(4)(H) of the Act for the statutory provision on this adjustment), rather than affiliated groups. In fact, the cited paragraph in the Conference Report starts out by stating: ''Among the specific issues that concerned the Conferees was application of a limit to new facilities, that is, hospitals or other entities which established programs after January 1, 1995.'' (Conference Report at 821). A separate provision on affiliations appears later in the Conference Report. The Report states: ''Another issue was the treatment of institutions which are members of an affiliated group. In some circumstances, the Conferees believe that the intent of this provision would best be met by providing an aggregate limit for such affiliates.'' Therefore, we believe that the language cited by the commenters was not meant to be applied to affiliated groups.

In addition, section 1886(h)(4)(H)(ii) of the Act specifies that ''The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary)'' to elect to apply the FTE cap on an aggregate basis (emphasis added). Thus, the statute granted the Secretary the discretion to promulgate regulations that specify what defines an affiliated group and when the FTE caps can be aggregated. Based on our analysis of the Conference Report language, as well as the statutory language, we believe the purpose of the affiliations provision is to provide temporary flexibility in the rotation of residents within the confines of the hospital-specific cap on the number of FTE residents. We do not believe the provision was meant to provide a vehicle for a hospital to circumvent the statutory FTE cap on the number of residents through permanent cap adjustments due to hospital closures.

Comment: Several commenters believed that the existing termination clause policy allowing for permanent cap adjustment ''is currently the only option available to retain'' resident slots due to hospitals or program closure. One commenter stated that the permanent transfer of residents through the use of affiliation agreement termination provisions allows the programs to continue to benefit the community indefinitely. Several of the commenters suggested that our existing policies specified at § 413.86(g)(8) that allow for temporary FTE cap adjustments to address hospital and residency program closure are ''short-lived'' and inadequate to address community needs.

Response: We understand that medical needs within a particular community may go unfulfilled whenever a hospital closes its doors, or even, in some communities, when a residency program closes. Our temporary FTE cap adjustments at § 413.86(g)(8) for hospital closures and also program closures are meant to address the situation of the residents who become ''displaced'' in either of the scenarios; they are not intended to address community medical needs (although, we know that in many cases, the temporary adjustments produce an incidental beneficial result to the community).

If Congress intended to provide permanent cap adjustments to address community needs because of hospital or program closures, we believe there would be such a provision in the Act. Until the law is amended to provide for such an explicit permanent adjustment to a hospital's FTE caps, we believe that our proposal for reverting back to pre-affiliation FTE caps upon affiliation termination is the proper policy.

Comment: Several commenters stated that the fact that a few hospitals abused the policy should not be a reason to make this policy change that affects all hospitals. One commenter believed that other appropriate safeguards can and should be put in place to avoid abuse. This commenter believed that abuse could be limited by requiring a hospital to have been part of the affiliated group for at least a full year prior to the termination of the agreement and not be part of temporary adjustment provided for at § 413.86(g)(8).

Response: In proposing the policy change requiring that when a Medicare affiliation agreement terminates, the hospitals' FTE caps revert to their original levels, we did not intend to target all hospitals due to the actions of, what the commenter has labeled, a few ''abusive hospitals.'' Rather, our intent was to clarify that we believe that any attempt to use affiliations to provide for a permanent increase in the FTE caps is not consistent with either the statute or Congressional intent.

As we noted in the preamble to the proposed regulations, in reviewing affiliation agreements that hospitals have submitted, we found that very few hospitals have altered their FTE caps following the termination of their affiliation agreements. Instead, they opt to revert to their 1996 base year caps. In fact, it is typically only where a hospital is about to close and there is the possibility that the hospital's FTE cap will be ''lost,'' that a termination clause is created to be used to transfer those slots to another hospital.

As stated above, section 1886(h)(4)(H)(ii) of the Act specifies that ''The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary)'' to elect to apply the FTE cap on an aggregate basis. We believe the basis of the policy on affiliations is to provide flexibility in the rotation of residents within the confines of the aggregate cap on the number of FTE residents. We do not believe this statutory provision was meant to provide a vehicle for a hospital to circumvent the statutory FTE cap on the number of residents through permanent cap adjustments due to

hospital closures. If Congress intended to provide for permanent cap adjustments to address situations where a hospital closes, we believe there would be a specific provision in the law to provide for such an adjustment.

Comment: We stated in the proposed rule (67 FR 31469), and also above, that the policy was proposed to be effective October 1, 2002, for hospitals with affiliation agreements that would terminate (for any reason) on or after that date. One commenter believed that the change should become effective with affiliations beginning, not terminating after October 1, 2002. Several other commenters agreed; they suggested that ''under no circumstances should a change be made that would retroactively affect an existing lawful agreement.'' Finally, one commenter suggested the change should apply only to agreements that were executed after the publication of the proposed rule so that, ''at least, it applies only to agreements in which the parties had notice of the anticipated change in policy.''

Response: We disagree with the commenters' suggestions. As we have stated above, we believe that the permanent FTE cap adjustment policy allows for the circumvention of the statutory caps. As such, we believe that the policy change should be applicable as soon as possible; that is, beginning with any terminations of affiliations that occur beginning with the effective date of this final rule.

We also disagree with the commenters that our policy change is ''retroactive''. If a hospital that is part of an already existing affiliated group decides for whatever reason to terminate the affiliation agreement, that termination would not retroactively affect the movement of the FTE caps back to their hospitals of origin. Rather, the reversion back to the pre-affiliation FTE caps occurs on a prospective basis after the termination has taken place.

Finally, to address the comment suggesting that the change in termination policy be effective with affiliation agreements executed after the publication of the proposed rule (which was on May 9, 2002), since the policy depends upon the action of a hospital terminating the affiliation agreement rather than executing the agreement, we believe it is more appropriate to maintain our proposed effective date. And, as we stated above, we believe the provider community is receiving adequate notice of this change in policy on terminations of affiliations through the notice and comment rulemaking process. Thus, we are adopting our proposal to require that the FTE caps for each hospital in the affiliated group will revert back to each hospital's FTE cap prior to entering into the affiliation upon termination of the affiliation.

Comment: Two commenters noted that the proposed rule stated that the FTE caps of hospitals in the affiliated group would revert back to their pre-affiliation levels upon termination. The commenters requested that, in cases where multiple hospitals enter into an affiliation agreement, but for whatever reason, one or more of the original affiliating hospitals wished to withdraw from the agreement, the remaining hospitals should be able to continue the affiliation agreement. One commenter stated that allowing affiliated groups to shrink from their original size to include only those hospitals that are interested in continuing their participation will ensure success of the affiliated group, while allowing CMS to reimburse hospitals subject to the limit of an aggregate cap. The commenter provided the following example: Hospitals A, B, and C enter into an affiliation agreement for the academic year beginning July 1, 2003. Each hospital has 1996 FTE caps of 8, respectively, which combine to equal an aggregate cap of 24. During this academic year, Hospital C decides to terminate its participation in the affiliated group. Hospital C takes back its 8 FTEs, its original FTE cap. Hospital A and Hospital B wish to continue affiliating, and Hospital A's FTE cap increases by 4 to equal 12, and Hospital B's FTE cap decreases by 4 to equal 4, for an aggregate cap of 16 FTEs.

Response: We believe the commenters may be confusing our proposal to require FTE caps of hospitals in the affiliated group to revert back to their pre-affiliation levels upon termination, with our policy with respect to hospitals that continue to affiliate. Our proposal would only preclude hospitals from using termination agreements as a means of permanently adjusting FTE caps. However, our proposal does not preclude hospitals from terminating their participation in an affiliation agreement, as long as each formerly participating hospital's respective original FTE caps are not changed as a result of the termination. Therefore, no modification to our regulations is necessary to adopt the commenters' request to allow affiliated groups to be reduced from their original size. The scenario described by the commenters is permissible under existing regulations. When a hospital withdraws from the affiliation, the equivalent amount of its pre-affiliation FTE cap is subtracted from the original aggregate cap, and reverts back to that hospital. The hospitals that wish to continue participating in the affiliation must submit a modified agreement to their respective intermediaries by June 30 of that academic year indicating the revised aggregate FTE cap, and adjustments to each hospital's caps, based only on the FTE caps of the hospitals that continue to affiliate.

Other Issues on Affiliated Groups

Comment: Two commenters requested that we remove our geographical restriction for hospitals to participate in an affiliated group; one commenter specifically requested that participants in an Osteopathic Postdoctoral Training Institution (OPTI) be permitted to participate in affiliated group without regard to geography. Two commenters requested that we change our policy at § 413.86(g)(6)(i)(D) concerning the prohibition of new teaching hospitals from participating in affiliated groups once the new residency program has been established. Another commenter asked that we define ''displaced residents'' for purposes of our policies at § 413.86(g)(8) on closed hospital and closed programs.

Response: Since these comments do not address issues that were specifically proposed in the May 9, 2002 notice of proposed rulemaking, we are not responding to these comments in this regulation.

Technical Corrections

We are making a technical change to the language under the definition of ''affiliated group'' under § 413.86(b) under paragraph (2). Paragraph (2) refers to hospitals that are jointly listed as the sponsor, primary clinical site, or major participating institution for one or more of the programs as these terms are used in the ''*Graduate Medical Education Directory, 1997–1998.*'' We note that the usage of the referenced terms has not changed in more recent publications of the Directory and is not expected to change in the future. Therefore, in this final rule, as part of our revision to the definition of ''affiliated group'' to incorporate the cross-training requirement for hospitals in an affiliation agreement, we are changing the reference to reflect use of the most current publication of that Directory.

When we issued the May 9, 2002 proposed rule, due to a typographical error, we inadvertently indicated that we proposed to make changes to § 413.86(g)(5)(iv) instead of § 413.86(g)(4)(iv) to incorporate revised provisions relating to determining the weighted number of FTE residents for hospitals that are part of the same affiliated group. As a result, we erroneously stated that we proposed to add a new paragraph under

§ 413.86(g)(5)(iv) and to redesignate paragraphs (g)(5)(iv), (g)(5)(v), and (g)(5)(vi) as paragraphs (g)(5)(v), (g)(5)(vi), and (g)(5)(vii) respectively to accommodate the new paragraph. We are correcting these errors in this final rule, We are changing the reference from § 413.86(g)(5)(iv) to § 413.86(g)(4)(iv). In addition, since we are revising § 413.86(g)(4)(iv) rather than inserting a new paragraph, there is no need to redesignate any paragraphs under § 413.86(g)(4).

4. Rotating Residents to Other Hospitals

At existing § 413.86(f), we state, in part, that a hospital may count residents training in all areas of the hospital complex; no individual may be counted as more than one FTE; and, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as a partial FTE based on the proportion of *time worked at the hospital* to the total time worked (emphasis added). A similar policy exists at §§ 412.105(f)(1)(ii) and (iii) for purposes of counting resident FTEs for IME payment. Although these policies concerning the counting of the number of FTE residents for IME and direct GME payment purposes have been in effect since October 1985, we continue to receive questions about whether residents can be counted by a hospital for the time during which the resident is rotated to other hospitals.

In the May 9, 2002 notice, we proposed clarifying that it is longstanding Medicare policy, based on language in both the regulations and the statute, to prohibit one hospital from claiming the FTEs training at another hospital for IME and direct GME payment. This policy applies even when the hospital that proposes to count the FTE resident(s) actually incurs the costs of training the residents(s) (such as salary and other training costs) at another hospital.

First, section 1886(h)(4)(B) of the Act states that the rules governing the direct GME count of the number of FTE residents ''shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.'' In the September 4, 1990 **Federal Register** (55 FR 36064), we stated that ''* * * regardless of which teaching hospital employs a resident who rotates among hospitals, each hospital would count the resident in proportion to the amount of time spent at its facility.'' Therefore, another hospital *cannot* count the time spent by residents training at another hospital. Only the hospital where the residents are actually training can count those FTEs for that portion of time. For example, if, during a cost reporting year, a resident spends 3 months training at Hospital A and 9 months training at Hospital B, Hospital A can only claim .25 FTE and Hospital B can only claim .75 FTE. Over the course of the entire cost reporting year, the resident would add up to 1.0 FTE.

We have been made aware of some instances where an urban hospital may incur all the training costs of residents while those residents train at a rural hospital, because the rural hospital may not have the resources or infrastructure to claim those costs and FTEs on a Medicare cost report. However, even in this scenario, the urban hospital is precluded from claiming any FTEs for the proportion of time spent in training at that rural hospital, or at any other hospital.

We note, however, that, consistent with the statutory provisions of section 1886(d)(5)(B)(iv) of the Act for IME payment and section 1886(h)(4)(E) of the Act for direct GME payment, a hospital may count the time residents spend training in a *nonhospital* setting if the hospital complies with the regulatory criteria at § 413.86(f)(4).

Comment: One commenter agreed that our clarification on the prohibition against a hospital counting residents training at other hospitals is one that is ''longstanding Medicare policy, based on language in both the regulations and the statute.'' As such, this commenter recommended that we amend our regulations to include this clarification as part of § 413.86(f)(2), ''rather than remain as a footnote to longstanding Medicare policy.''

Response: As we clarified in the proposed rule and also above, existing § 413.86(f) states, in part, that a hospital may count residents in all areas of the hospital complex; no individual may be counted as more than one FTE; and, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as a partial FTE based on the proportion of *time worked at the hospital* to the total time worked (emphasis added). A similar policy exists at §§ 412.105(f)(1)(ii) and (iii) for purposes of counting resident FTEs for IME payment. Thus, we believe our existing regulations are already very clear that hospitals cannot count resident rotations at other hospitals; indeed, the hospital can only count residents working ''at the hospital''. However, because we continue to receive many questions on this policy, even though it is a longstanding one, in this final rule we are revising §§ 413.86(f) and 412.105(f) to explicitly prohibit the counting of residents at other hospitals.

As we stated above, and also in the proposed rule, we are aware of some scenarios where one hospital incurs the residency training costs of residents training at other hospitals. However, even in this scenario, the hospital incurring the costs of the residents at the other hospitals is precluded from claiming any FTEs for the proportion of time spent in training at the other hospitals.

Comment: One commenter stated that CMS should consider allowing hospitals to enter into agreements that would permit one hospital to claim the resident FTE time worked at another hospital as long as the hospital claiming the resident time is incurring ''all or substantially all'' of the training costs at the other hospitals, similar to the regulations specified at existing § 413.86(f)(4) for nonhospital sites.

Another commenter stated that it disagrees with our clarification concerning the situation where a teaching hospital cannot count resident rotations to nonteaching hospitals, even when the teaching hospital incurs ''all or substantially all'' of the costs and the rotation is part of the accredited program. One commenter requested that it be allowed to count the ''round time'' at another hospital. One commenter requested clarification on whether our policy that prohibits a hospital from counting residents rotating to other hospitals applies to the situation where residents rotate to hospitals not participating in Medicare, such as State-operated psychiatric facilities and hospitals located in foreign countries.

Response: We do not believe that it is consistent with the requirements at sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act to expand the policy at § 413.86(f)(4) concerning counting residents in nonhospital settings to allow hospitals to count residents training at other hospitals even if the hospitals seeking to count the residents incur ''all or substantially all'' of the costs. In fact, it is only because the statute has specifically provided for counting residents training at nonhospital sites that it is appropriate to include any resident not training at the hospital in the hospital's FTE count.

In addition, section 1886(h)(4)(A) of the Act requires the Secretary to establish rules for the computation of FTE residents in an approved medical residency training program. Furthermore, at paragraph (B) of that section, the statute requires that the regulations take into account individuals who serve as residents simultaneously with more than one

hospital. Therefore, we believe that the Secretary has the authority to allow a hospital to count only those residents actually training in that hospital. Even where the residents are training at other hospitals or foreign hospitals, it is not appropriate for the hospital to include those residents in its FTE count. Further, although the commenter refers to rotations occurring at ''nonteaching'' hospitals, we note that by virtue of the fact that residents are rotating and training at a hospital, the hospital is, by definition, a teaching hospital. In fact, each Medicare-participating hospital at which the residents are rotating over the course of the program year should be completing the direct GME and IME (if applicable) worksheets of the Medicare cost report in order to claim and receive Medicare payment for their respective portions of the FTE training time, regardless of whether the hospital incurs any costs for training those residents. Accordingly, we are not adopting the policy change suggested in these comments.

J. Responsibilities of Medicare-Participating Hospitals in Emergency Cases (EMTALA)

In the May 9, 2002 proposed rule, we presented certain proposed policies to clarify areas of the regulations under § 489.24 that implemented sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act and solicited comments from hospitals, physicians, patients, and beneficiary groups. These sections of the Act impose specific obligations on Medicare-participating hospitals that have an emergency department. These obligations concern individuals who come to a hospital emergency department and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether or not they are beneficiaries of any program under the Act. These provisions of the Act, taken together, are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the antidumping statute.

In response to our proposals, we received approximately 600 pieces of correspondence, most of which contained multiple comments. A large number of the comments were received on the last day of the comment period for the proposed rule (July 8, 2002). Because of the number and nature of the public comments we received on our proposed clarifications and our limited timeframe for developing the final acute care hospital inpatient prospective payment system regulations for publication by the statutory deadline of August 1, we have decided, with one exception, to address the public comments and finalize the proposals in a separate document. The one proposal being finalized in this document is our proposed revision to the second sentence of § 413.65(g)(1) to clarify the application of EMTALA to provider-based entities. That proposal, and the action we are taking with respect to it, are described more fully in section V.L.2.g. (Clarification of Obligations of Hospital Outpatient Departments and Hospital-Based Entities) of this preamble.

K. Provider-Based Entities

1. Background

a. The April 7, 2000 Final Rule

Since the beginning of the Medicare program, some providers, which we refer to as ''main providers,'' have functioned as a single entity while owning and operating multiple provider-based departments, locations, and facilities that were treated as part of the main provider for Medicare purposes. Having clear criteria for provider-based status is important because this designation can result in additional Medicare payments for services furnished at the provider-based facility, and may also increase the coinsurance liability of Medicare beneficiaries for those services.

In the April 7, 2000 **Federal Register** (65 FR 18504), we published a final rule specifying the criteria that must be met for a determination regarding provider-based status. The regulations at § 413.65(a)(2) define provider-based status as ''the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of this section.'' The regulations at existing § 413.65(b)(2) state that before a main provider may bill for services of a facility as if the facility is provider-based, or before it includes costs of those services on its cost report, the facility must meet the criteria listed in the regulations at § 413.65(d). Among these criteria are the requirements that the main provider and the facility must have common licensure (when appropriate), the facility must operate under the ownership and control of the main provider, and the facility must be located in the immediate vicinity of the main provider.

The effective date of these regulations was originally October 10, 2000, but was subsequently delayed. Except where superseded by new legislation, § 413.65 is now in effect for new facilities or organizations for cost reporting periods beginning on or after January 10, 2001, as explained further below. Program instructions on provider-based status issued before that date, found in Section 2446 of the Provider Reimbursement Manual, Part 1 (PRM–1), Section 2004 of the Medicare State Operations Manual (SOM), and CMS Program Memorandum (PM) A–99–24, will apply to any facility for periods before the new regulations become applicable to it. (Some of these instructions will not be applied because they have been superseded by specific legislation on provider-based status, as described in section V.L.3. of this preamble).

b. Frequently Asked Questions Regarding Provider-Based Issues

Following publication of the April 7, 2000 final rule, we received many requests for clarification of policies on specific issues related to provider-based status. In response, we published a list of ''Frequently Asked Questions'' and the answers to them on the CMS website at *www.hcfa.gov/medlearn/provqa.htm.* (This document can also be obtained by contacting any of the CMS Regional Offices.) These questions and answers did not revise the regulatory criteria, but do provide subregulatory guidance for their implementation.

c. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554)

On December 21, 2000, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Public Law 106–554) was enacted. Section 404 of BIPA contains provisions that significantly affect the provider-based regulations at § 413.65. Section 404 includes a grandfathering provision for facilities treated as provider-based on October 1, 2000; alternative criteria for meeting the geographic location requirement; and criteria for temporary treatment as provider-based.

(1) Two-Year ''Grandfathering''

Under section 404(a) of BIPA, any facilities or organizations that were ''treated'' as provider-based in relation to any hospital or CAH on October 1, 2000, will continue to be treated as such until October 1, 2002. For the purpose of this provision, we interpret ''treated as provider-based'' to include those facilities with formal CMS determinations, as well as those facilities without formal CMS determinations that were being paid as provider-based as of October 1, 2000. As a result, existing provider-based facilities and organizations may retain that status without meeting the criteria

in the existing regulations under §§ 413.65(d), (e), (f), and (h) until October 1, 2002. These provisions concern provider-based status requirements, joint ventures, management contracts, and services under arrangement. Thus, the provider-based facilities and organizations affected under section 404(a) of BIPA are not required to submit an application for or obtain a provider-based status determination in order to continue receiving reimbursement as provider-based during this period.

These provider-based facilities and organizations are not exempt from the EMTALA responsibilities of provider-based facilities and organizations set forth at § 489.24 or from the other obligations of hospital outpatient departments and hospital-based entities in existing § 413.65(g), such as the responsibility of off-campus facilities to provide written notices to Medicare beneficiaries of coinsurance liability. These rules are not preempted by the grandfathering provisions of section 404 of BIPA because they do not set forth criteria that must be met for provider-based status as a department of a hospital, but instead identify responsibilities that flow from that status. These responsibilities become effective for hospitals on the first day of the hospital's cost reporting period beginning on or after January 10, 2001.

(2) Geographic Location Criteria

Section 404(b) of BIPA provides that those facilities or organizations that are not included in the grandfathering provision at section 404(a) are deemed to comply with the ''immediate vicinity'' requirements of the existing regulations under § 413.65(d)(7) if they are located not more than 35 miles from the main campus of the hospital or CAH. Therefore, those facilities located within 35 miles of the main provider satisfy the immediate vicinity requirement as an alternative to meeting the ''75/75 test'' under existing § 413.65(d)(7).

In addition, BIPA provides that certain facilities or organizations are deemed to comply with the requirements for geographic proximity (either the ''75/75 test'' or the ''35-mile test'') if they are owned and operated by a main provider that is a hospital with a disproportionate share adjustment percentage greater than 11.75 percent and is (1) owned or operated by a unit of State or local government, (2) a public or private nonprofit corporation that is formally granted governmental powers by a unit of State or local government, or (3) a private hospital that has a contract with a State or local government that includes the operation of clinics of the hospital to ensure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare or Medicaid.

These geographic location criteria will continue indefinitely. While those facilities or organizations treated as provider-based on October 1, 2000 are covered by the 2-year grandfathering provision noted above, the geographic location criteria at section 404(b) of BIPA and the existing regulations at § 413.65(d)(7) will apply to facilities or organizations not treated as provider-based as of that date, effective with the hospital's cost reporting period beginning on or after January 10, 2001. On October 1, 2002, the statutory moratorium on application of these criteria to the grandfathered facilities will expire. However, as we discussed in the May 9, 2002 proposed rule, we are providing for a further delay, as discussed below.

(3) Criteria for Temporary Treatment as Provider-Based

Section 404(c) of BIPA provides that a facility or organization that seeks a determination of provider-based status on or after October 1, 2000, and before October 1, 2002, shall be treated as having provider-based status for any period before a determination is made. Thus, recovery for overpayments will not be made retroactively once a request for a determination during that time period has been made. A request for provider-based status should be submitted to the appropriate CMS Regional Office. Until a uniform application is available, at a minimum, the request should include the identity of the main provider and the facility or organization for which provider-based status is being sought and supporting documentation for purposes of applying the provider-based status criteria in effect at the time the application is submitted. Once such a request has been submitted on or after October 1, 2000, and before October 1, 2002, CMS will treat the facility or organization as being provider-based from the date it began operating as provider-based until the effective date of a CMS determination that the facility or organization is not provider-based.

The provision concerning temporary treatment as provider-based in section 404(c) of BIPA is effective only for requests filed before October 1, 2002. As explained further below, the procedures in new § 413.65(b)(3) will be followed in making any determinations of provider-based status in response to attestations submitted on or after October 1, 2002.

d. The August 24, 2001 and November 30, 2001 Published Regulations

In August 24, 2001 **Federal Register** (66 FR 44672), we proposed to revise the provider-based regulations to reflect the changes mandated by section 404 of BIPA and to make other technical and clarifying changes in those regulations. In the November 30, 2001 **Federal Register** (66 FR 59856), following consideration of public comments received on the August 24, 2001 proposal, we published a final rule that revised the provider-based regulations. However, the only substantive changes in the provider-based regulations were those required by the BIPA legislation.

2. Proposed Changes in the May 9, 2002 Proposed Rule

In the preamble to the proposed rule published on August 24, 2001 (66 FR 44709), we stated our intent to reexamine the EMTALA regulations and, in particular, to reconsider the appropriateness of applying EMTALA to off-campus locations. We announced that we planned to review these regulations with a view toward ensuring that these locations are treated in ways that are appropriate to the responsibility for EMTALA compliance of the hospital as a whole. We also pointed out that, at the same time, we want to ensure that those departments that Medicare pays as hospital-based departments are appropriately integrated with the hospital as a whole.

In addition, since the statutory grandfathering provision in the BIPA legislation remains in effect only until October 1, 2002, many hospital representatives have contacted CMS to request more guidance because they are concerned that their facilities are not in compliance with existing regulations and would not be able to continue billing as provider-based once the grandfathering provision expires. These hospital representatives are also concerned that the organizational and contractual changes needed to meet current provider-based requirements could take several months to complete. Moreover, resolution of some of the issues surrounding the provider-based regulations is needed in order to allow development of a uniform application form to enable the CMS Regional Offices to efficiently process the multitudes of requests for provider-based determinations that we expected as the grandfathering period expires.

To address the provider-based issues raised by the hospital industry and to allow for an orderly and uniform implementation strategy once grandfathering ends, in the May 9, 2002

proposed rule, we proposed the following regulatory changes:

a. Scope of Provider-Based Requirements (§ 413.65(a))

Since publication of the April 2000 final rule, we have received many questions about which specific facilities or organizations are subject to the provider-based requirements. In the ''Frequently Asked Questions'' posted on the CMS website, we identified a number of facility types for which provider-based determinations would not be made, since such determinations would not affect either Medicare payment or Medicare beneficiary liability or scope of benefits. The regulations at § 413.65(a) were further revised to incorporate the exclusion of these facility types from review under the provider-based criteria. We proposed to further revise § 413.65(a)(1)(ii) to state that provider-based determinations will not be made with respect to independent diagnostic testing facilities that furnish only services paid under a fee schedule, such as facilities that furnish only screening mammography services, as defined in section 1861(jj) of the Act, facilities that furnish only clinical diagnostic laboratory tests, or facilities that furnish only some combination of these services. A provider-based determination is not necessary to resolve payment issues for a facility that furnishes only screening mammography because of a change made by section 104 of BIPA. That legislation, which amended section 1848(j)(3) of the Act, mandates that all payment for screening mammography services furnished on or after January 1, 2000, be made under the Medicare Physician Fee Schedule (MPFS). Under the MPFS methodology, Medicare payment for the service, regardless of the setting in which it is furnished, is set at the lesser of the fee schedule amount or the actual charge; and no Part B deductible applies. Regardless of the setting, Part B coinsurance is assessed at 20 percent of the lesser of the fee schedule amount or the actual charge. Because the status of a facility as provider-based or freestanding would not affect the amount of Medicare or Medicaid payment, the beneficiary's scope of benefits, or the beneficiary's liability for coinsurance or deductible amounts, it is not necessary to make a provider-based determination regarding facilities that furnish only screening mammography. We also proposed to revise § 413.65(a)(1)(ii) by adding a new paragraph (J) to state that we will not make provider-based determinations with respect to departments of providers (for example, laundry or medical records departments) that do not furnish types of health care services for which separate payment could be claimed under Medicare or Medicaid. (Such services frequently are referred to as ''billable'' services.) As explained more fully below, we would not make determinations with respect to these departments because their status (that is, whether they are provider-based or not) would have no impact on Medicare or Medicaid payment or on the scope of benefits or beneficiary liability under either program.

Despite the previous clarifications described above, providers, associations, and their representatives have continued to state that they are confused as to which facilities or organizations will be the subject of provider-based determinations.

In the May 9, 2002 proposed document, we proposed to further clarify the types of facilities that are subject to the provider-based rules, by making several changes to the definitions of key terms in § 413.65(a)(2). First, we proposed to revise the definition of ''department of a provider'' to remove the reference to a physician office as being a department of a provider. While a hospital outpatient department, in fact, may furnish services that are clinically indistinguishable from those of physician offices, physician offices and provider departments are paid through separate methods under Medicare and beneficiaries may be liable for different coinsurance amounts. Thus, it is essential to distinguish between these facility types, and we believe avoiding confusion on this issue requires us to remove the reference to a hospital department as a physician office.

We also proposed to revise § 413.65(a)(2) to state that a ''department of a provider'', ''provider-based entity'', or ''remote location of a hospital'' comprises both the specific physical facility that serves as the site of services of a type for which separate payment could be claimed under the Medicare or Medicaid programs, and the personnel and equipment needed to deliver the services at that facility. We proposed this change because we believed it would help to clarify that we would make determinations with respect to entities considered in their role as sources of health care services and not simply as physical locations. We also clarified that we do not intend to make provider-based determinations with respect to various organizational components or units of providers that may be designated as ''departments'' or ''organizations'' but do not themselves furnish types of services for which separate payment could be claimed under Medicare or Medicaid. Examples of components for which we would not make provider-based determinations include the medical records, housekeeping, and security departments of a hospital. Such departments do perform functions that are essential to the provision of inpatient and outpatient hospital services, but the departments do not provide health care services for which Medicare or Medicaid benefits are provided under title XVIII or title XIX of the Act, and for which separate payment therefore could be claimed, assuming certification and other applicable requirements were met, to one or both programs. Therefore, neither Medicare or Medicaid program liability nor beneficiary liability or scope of benefits would be affected by the ability or inability of these departments to qualify as ''provider-based.''

By contrast, Medicare or Medicaid payment (or both) to hospital departments that provide diagnostic or therapeutic radiology services to outpatients, or primary care, ophthalmology, or other specialty services to outpatients are affected by provider-based status, as would beneficiary liability for Medicare coinsurance amounts. Therefore, we would make provider-based determinations for these departments.

Similarly, if two acute care hospitals that have approved graduate medical education (GME) programs were to merge to form a single, multicampus hospital consisting of the main hospital campus and a remote location, it would be appropriate to make a determination as to whether the remote location is provider-based with respect to the main hospital campus. Such a determination would be needed because each hospital with an approved residency training program has its own hospital-specific cap on the number of residents (or FTE cap), its own PRA, and its own Medicare utilization used for purposes of receiving Medicare GME payments. A merger of the two hospitals would aggregate the two hospitals' individual FTE caps into a merged FTE cap under the main hospital's provider number, and would require recalculation of the hospital's PRA and a merging of these entities' respective Medicare utilization, resulting in a level of Medicare GME payment to the merged hospital that could exceed the sum of the payments that would be made to each hospital as separate entities. Thus, a provider-based determination would be appropriate and necessary in such a case, even though payment for services by both facilities,

even if they are not provider-based, would be made under the Medicare acute care hospital inpatient prospective payment system.

In deciding whether to make a provider-based determination with respect to a particular facility, it would not be significant that the facility might have a low rate of Medicare utilization, might be utilized by only Medicare or only Medicaid patients, or might not have admitted any Medicare or Medicaid patients in a particular period. The fact that the facility furnishes types of services that are billable under Medicare or Medicaid, or both, would be sufficient to make a determination appropriate.

We proposed to retain the rules that a department of a provider or a remote location of a hospital (such as, for example, one campus of a multicampus hospital) may not by itself be qualified to participate in Medicare as a provider under the regulations on provider agreements in § 489.2, and the Medicare conditions of participation do not apply to a department as an independent entity. However, we proposed to delete the requirement at § 413.65(a)(2) that such a department may not be licensed to provide services in its own right. Some States require separate licensing of facilities that Medicare would treat as a department of a hospital or other provider. In these States, we would not require a common license. We proposed to retain the provision that, for purposes of Part 413, the term ''department of a provider'' does not include an RHC or, except as specified in § 413.65(m), an FQHC. (As explained below, existing § 413.65(m) is being redesignated as § 413.65(n) in this final rule.)

Questions have arisen regarding whether the provider-based criteria in § 413.65 are applicable in determining payment for ambulance services. Medicare is converting payment for ambulance services to a fee schedule, as described in a final rule published on February 27, 2002 (67 FR 9100). The ambulance fee schedule is effective April 1, 2001, and involves a transition period. During this transition period, the status of an ambulance supplier as provider-based could influence the amount of Medicare payment. However, the specific provider-based criteria in § 413.65 were not developed for ambulance suppliers, and we believe that many of these criteria could not reasonably be applied to them. Therefore, we did not propose to apply the criteria at § 413.65 to ambulance services.

We note that, in the May 9, 2002 proposed rule, we inadvertently did not make a conforming change to the regulations at § 413.65(a) to state that the provider-based rules do not apply to ambulances. Therefore, we are making this conforming change in this final rule.

Comment: One commenter recommended that all inpatient departments be exempt from the provider-based rules, regardless of whether they are on campus or off campus, since, due to their ''very status as inpatient departments, they are necessarily integrated into the operations of the main provider. * * *'' Several other commenters recommended that ancillary or other departments located within a hospital (that is, on campus) be deemed to be provider-based and thus not be required to show actual compliance with provider-based criteria.

Response: We do not agree that facilities that treat a patient population made up primarily or entirely of inpatients should necessarily be considered, on that basis alone, to be a fully subordinate and integral component of the main provider. There are instances where a Medicare payment differential exists between a hospital-based inpatient service and a freestanding service. For example, if an institution that primarily provides inpatient care is able to participate in Medicare as a part of a hospital, Medicare payment to the hospital will be made for the full range of inpatient hospital services defined in section 1861(b) of the Act. If the facility is not considered a part of a Medicare-participating hospital, Medicare payment would be made only for a much narrower range of services, such as physical and other therapies, which can be paid in ambulatory care settings. Compliance with the provider-based criteria is also needed to ensure that Medicare payment is made appropriately in merger situations, where the crucial issue is whether a facility is integral and subordinate to another that participates as a hospital. For example, under the TEFRA payment system applicable to psychiatric, children's and cancer hospitals, Medicare payment to the hospital for inpatient services usually is directly affected by the hospital-specific TEFRA target rate. If a particular hospital chooses to reorganize to include a new site that otherwise could participate in Medicare only as a separate hospital or as a remote location or satellite of still another hospital, the amount of payment would be affected. Similarly, for the reasons explained in detail in the May 9, 2002 proposed rule (67 FR 31482), a merger of two hospitals can significantly affect the payments made to them for their GME programs, even when each hospital is paid under the acute inpatient hospital prospective payment system. Under these circumstances, compliance with the provider-based criteria is also needed to warrant the higher payment level that would result.

We also do not agree that location on the main campus of a hospital should be the sole determinant of provider-based status, since hospitals can and frequently do lease space on their campuses to physicians and other providers or suppliers of health services, and these providers or suppliers may have no more connection to or integration into the hospital's operations than the lease agreement and physical proximity. For example, a hospital may lease some of its space to an independent diagnostic testing facility (IDTF) that furnishes radiology services, which are frequently considered by hospitals to be among their ancillary services. Such a facility could be paid significantly more as a provider-based department than as a freestanding facility. Because of this payment difference, we believe it is important that the facility meet standards that establish that it is an integral and subordinate part of the main provider hospital, and thus that the higher payment level associated with provider-based status is warranted. Therefore, we are not revising this final rule to permit on-campus facilities to qualify as provider-based solely because of location.

Comment: One commenter suggested that consolidations of facilities on separate campuses should not be subject to the provider-based requirements, but should be regulated only by the requirements on State licensure, Medicare certification, and Medicare enrollment.

Response: For the reasons explained in the response to the preceding comment, consolidation of facilities under a single provider number frequently has significant implications for Medicare payment levels. In many cases, the amount paid for services of a consolidated facility can be significantly more than the sum of what would be paid to two or more separate facilities for the provision of identical services. Current State licensure and Medicare certification requirements are focused on the protection of patient health and safety, and the determination of whether a facility is part of the main provider is not central to that concern. On the contrary, licensure and certification requirements may be easily manipulated by providers seeking to maximize payment under Medicare or Medicaid

without improving either the quantity or the quality of care furnished. Thus, it is crucial that we establish criteria to ensure that consolidated facilities are truly integral and subordinate to a single main provider.

Comment: Some commenters wrote on behalf of multicampus hospitals that operate under a single provider number and agreement, but include several campuses that are separately licensed by the State. The commenters stated that they have been structured in this way since before the inception of the Medicare program and thus did not adopt their current structures in an effort to maximize GME or DSH payments. The commenters explained that if multicampus hospitals are not exempted from the provider-based requirements, the hospitals would have to either designate one campus as the main campus and rearrange the clinical, financial, and other arrangements between the hospitals in order to comply with the provider-based requirements, or obtain a separate Medicare provider agreement and number for each campus. If the second course were chosen, total Medicare payment to the separate hospitals would be considerably less than what is currently being paid to them as multicampus organizations. Because the hospitals are unwilling to pursue either of the options outlined above, the commenter requested that either all multicampus hospitals be exempted from the provider-based requirements, or that an exemption be created for any such hospitals that have been structured as multicampus hospitals since the beginning of the Medicare program.

Response: We understand the commenter's concern, but for the reasons cited earlier in this preamble believe that it is important to apply the provider-based criteria to multicampus hospitals in which each campus is separately licensed, as well as to those in which all components operate under a single State license. In particular, such an exemption could lead to increased levels of Medicare GME and DSH payments, relative to the amounts payable if the provider-based criteria were applied. In fact, the commenter admitted that Medicare payment to the separate hospitals would be considerably less than what is paid to them as a single but multicampus hospital. We continue to believe it is important to pay for services of hospital facilities as part of a single hospital only when they meet the provider-based criteria we have established. Therefore, we are not adopting this comment.

Comment: One commenter requested more clarification of how the provider-based criteria apply to multicampus hospitals, and to multihospital systems (that is, chain organizations that include two or more hospitals, each of which participates separately in Medicare). The commenter was particularly interested in learning what would be the main campus of a multihospital system, and whether a facility or organization at one location of a multihospital system could be provider-based with respect to another hospital in that system.

Response: If a hospital comprises several sites at which both inpatient and outpatient care are furnished, it will normally be necessary for the hospital to designate one site as its ''main'' campus for purposes of the provider-based rules. Each of the other sites (referred to in our regulations as ''remote locations'') would then be expected to meet the provider-based requirements with respect to that main campus. Thus, any facility not located on a hospital's main campus would be considered to be an ''off-campus'' facility. Hospitals would normally be given considerable discretion in selecting which site is to be the ''main'' campus for provider-based purposes. In such a case, any outpatient facility also providing services at a ''remote location'' that are to be billed as services of the hospital would be considered as a potential hospital department for purposes of provider-based status and would be expected to meet the provider-based criteria with respect to the location designated by the hospital as its main campus. However, it is important to note that the provider-based criteria apply to individual hospitals, not to multihospital systems (for example, systems owned and operated by chain organizations). Where such a system exists, its hospitals will participate separately in Medicare, and the provider-based criteria will apply separately to each hospital in the chain. If a facility or organization located on the campus of one hospital in the chain wishes to be treated as part of another, separately participating hospital in the chain, the facility or organization would have to meet the provider-based criteria with respect to that hospital, on the same basis as if the two hospitals were not part of the same chain organization.

Comment: Several commenters stated that, in some areas, it is common for children's hospitals to set up and staff neonatal intensive care units (NICUs) in community hospitals, in order to extend these services into rural areas where they might not otherwise be available. The commenter noted that these units frequently cannot meet the location requirement for provider-based status in § 413.65(e)(3) of the proposed regulations, and asked that the final rule be revised to create a special exception to this requirement, to allow these units to continue to be treated as provider-based once the grandfathering period ends and to permit the creation of new units of the same type.

Response: We understand these commenters' concerns, but note that these units raise serious questions about the appropriate treatment of facilities located at long distances from the main children's hospital that nevertheless claim to be a part of that hospital. While these facilities may have very limited Medicare utilization, they frequently receive substantial amounts of payment under Medicaid, thus making it important to ensure that they are classified and paid appropriately. After considering these issues, we have concluded that it would not be appropriate to waive the location requirement for provider-based status, or make some other ad hoc exception to the provider-based criteria, for these facilities. However, we have explained in the FAQs the inability of units in certain locations to qualify for provider-based status does not preclude States from adopting revisions to their Medicaid plans to provide more generous payment to such units. While we are not making a special exception for NICUs, we recognize the importance of further emphasizing that when a payment difference exists, compliance with the provider-based rules is needed to justify payment for services in a facility as provider-based. Therefore, in this final rule, we are clarifying the regulations at § 413.65(a) to state that the determinations of provider-based status are made for payment purposes.

Comment: Some commenters requested clarification of how the provider-based criteria apply to multicampus hospitals that participate in Medicare under a single provider number but comprise two or more campuses that are physically separate from one another. The commenters were particularly concerned about which campus is to be identified as the main campus and about whether clinics or other facilities located on one campus of a hospital may be considered provider-based with respect to another campus.

Response: We agree that multicampus hospitals present special implementation issues. However, the following general principles will be applied. First, when hospital facilities are dispersed among two or more geographically separate campuses, it will be necessary for one of the campuses to be designated by the hospital as the main campus. Facilities at the other campus(es) would be

considered provider-based only if they meet the provider-based criteria in relation to the main campus. We would normally accept the provider's own selection of a main campus, unless the regional office concludes, in a particular case situation, that the campus selected by the provider clearly does not actually function as the main campus. The location requirements for a facility at a campus other than the main campus would be applied based on the distance between the facility and the main campus. Hospital chain organizations, which include a number of separately certified hospitals, would not be considered multicampus hospitals.

Comment: One commenter stated that the provider-based criteria are being applied under Medicaid only because the same certification standards apply under Medicaid as under Medicare. The commenter also pointed out that States are not required to follow Medicare payment system rules in making payment under their Medicaid programs. The commenter then argued that this State flexibility to determine Medicaid payment means that CMS should prohibit States from applying the provider-based criteria in determining payment under Medicaid.

Response: The commenter is correct in noting that the Medicaid regulations at 42 CFR 440.10 and 440.12 define inpatient and outpatient hospital services, for Medicaid purposes, as services furnished in or by an institution that meets the requirements for participation in Medicare as a hospital. Medicare participation by an institution as a hospital is contingent on the institution's compliance with many participation requirements, not merely the health and safety rules set forth in 42 CFR Part 482. The institution is also required under section 1866 of the Act and regulations at 42 CFR Part 489 to comply with various other statutory and regulatory provisions relating to (among other areas) charges to beneficiaries, maintenance of billing and other records, and the screening and stabilization, or appropriate transfer, of emergency cases. To the extent the hospital is required to comply with the provider-based criteria in Medicare regulations as part of its Medicare hospital participation obligations, the definitions of services in § 440.10 and 440.12 also require that it comply with these requirements for Medicaid purposes.

Regarding the commenter's remarks on State flexibility, we recognize that States are authorized to adopt, through their State plans, payment definitions and methods that differ from those used under Medicare. Thus, the commenter is correct in noting that a State may adopt payment methods that do not differentiate between facilities that meet the provider-based requirement and those that do not. To the extent that States amend their State plans to contain such payment methods, we do not object to these actions. However, we do not believe it would be consistent with State flexibility to prohibit States that wish to apply provider-based criteria in making their payment decisions from doing so. Such a prohibition would not benefit either States or their Medicaid recipients and, on the contrary, could increase State and Federal Medicaid spending unnecessarily. Therefore, we are not making any change in this final rule based on this comment.

Comment: Several commenters noted that Indian Health Service (IHS) and tribal clinics and other facilities meeting the criteria in § 413.65(l) (redesignated as § 413.65(m) in this final rule) are in effect excluded from the scope of the provider-based criteria by the grandfathering provision included in that section. The commenters further noted that under Public Law 93–638, the Indian Self-Determination Act, as amended, tribes have the right to contract for the management of all or a portion of the IHS programs that provide services in their communities. The commenters pointed out that tribal and IHS facilities remain the primary source of health care in many remote rural communities. However, because of the unique IHS and tribal administrative systems, many clinics and other facilities that might lose their grandfathered status under § 413.65(l) (redesignated as § 413.65(m) in this final rule) are not able to meet provider-based criteria. To avoid disrupting the operation of these vital sources of care in remote rural areas, and consistent with the objectives of the Indian Self-Determination Act, the commenters recommended that all clinics and other facilities operated by IHS or tribes should be exempted from the provider-based regulations.

Response: We understand the concern about the need to preserve access to health care by patients using IHS facilities in rural communities. However, we note that existing § 413.65(l) provides grandfathering protection for the facilities in operation when the existing provider-based rules were published, and that section 432 of BIPA amended the Medicare statute to permit payment for physician services in IHS clinics, thus providing an alternate funding source for facilities that become freestanding. Therefore, we do not believe a further change of the kind recommended by the commenter is needed.

Comment: One commenter noted that excluding facilities providing only physical, occupational, or speech therapy to ambulatory patients from the provider-based requirements does not meet CMS' own stated criteria for such exclusions, in cases where those facilities are operated by CAHs. A payment difference based on provider-based or freestanding status would exist in such cases. If such facilities were operated as freestanding they would be paid on a fee schedule basis. However, if they were operated as integral and subordinate parts of CAHs, they would be paid on the same reasonable cost basis as other components of the CAH. The commenter recommended that the exclusion language in § 413.65(a)(1)(ii)(H) be revised to state that the exclusion applies to such facilities other than those which are operated as part of a CAH.

Response: We agree and are revising this final rule to reflect this comment.

Accordingly, we are adopting as final the proposed revision to § 413.65(a)(1)(ii)(G), the addition of § 413.65(a)(1)(ii)(J), and the revisions of the definitions of ''Department of a provider,'' ''Provider-based entity'' and ''Remote location of a hospital under § 413.65(a)(2). In addition, in response to public comments, we are revising existing § 413.65(a)(1)(ii)(H) to clarify that the exclusion of facilities providing only physical, occupational, or speech therapy to ambulatory patients applies to these facilities only if they are not operated as part of a CAH.

b. Further Delay in Effective Date of Provider-Based Rules

As noted earlier, § 413.65(b) was recently revised to reflect the ''grandfathering'' provision in section 404(a)(1) of BIPA. Under that provision, if a facility was treated as provider-based in relation to a hospital or CAH on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until October 1, 2002.

To allow hospitals and other facilities the time they need to make contractual and organizational changes to comply with the new rules, and to ensure that CMS Regional Offices and contractors are able to provide for an orderly transition to the new provider-based rules, we believed an additional delay in the effective date of the provider-based criteria is needed. Therefore, in the May 9, 2002 proposed rule we proposed to revise § 413.65(b)(2) to state that if a facility was treated as provider-based in relation to a hospital or CAH

on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until the start of the hospital's first cost reporting period beginning on or after July 1, 2003. We proposed to further provide that the requirements, limitations, and exclusions specified in § 413.65(d) through (j) (as proposed to be redesignated) will not apply to that hospital or CAH for that facility until the start of the hospital's first cost reporting period beginning on or after July 1, 2003. For purposes of paragraph (b)(2), a facility would be considered as having been provider-based on October 1, 2000, if on that date it either had a written determination from CMS that it was provider-based, or was billing and being paid as a provider-based department or entity of the hospital. We proposed to make the new requirements effective on October 1, 2002, with respect to provider-based status for facilities not qualifying for the grandfathering provision.

Comment: One commenter requested clarification of how the proposed delay in effective date for the facilities grandfathered under section 404(a) of BIPA will be applied. Specifically, the commenter asked whether facilities benefiting from the grandfathering would be able to take advantage of any additional flexibility provided under the final rules before the hospital's first cost reporting period beginning on or after July 1, 2003.

Response: As explained in the preamble to the proposed rule, the purpose of the delayed effective date for grandfathered facilities is to allow more time for any necessary contractual or organizational changes that hospitals or their grandfathered facilities might need to undertake to achieve actual compliance with the provider-based criteria. Under our proposal, this would be accomplished by simply extending the BIPA mandated grandfathering provision until the hospital's first cost reporting period beginning on or after July 1, 2003. To clarify the effect of the delay, we are revising the final rule to specify that the grandfathering provision applies to the requirements, limitations, and exclusions specified in paragraphs (d), (e), (f), (h), and (i) of § 413.65 of this final rule. To the extent a particular grandfathered hospital might benefit from any other changes in paragraphs of § 413.65 other than those listed in the immediately preceding sentence, it would be able to receive that benefit as of October 1, 2002, which is the effective date of any revisions to the other paragraphs.

Comment: Several commenters requested that the grandfathering of facilities treated as provider-based on October 1, 2000 should continue indefinitely, not just until the start of the first cost reporting period on or after July 1, 2003, as we had proposed.

Response: We are providing an extension in the effective date of the provider-based rules for grandfathered facilities until cost reporting periods beginning on or after July 1, 2003, to allow these facilities sufficient time to make any contractual and organizational changes needed to comply with the new rules. However, we do not believe it is appropriate to allow the facilities that were treated as provider-based in the past to continue to be treated that way permanently, without ever having to meet the same requirements as newer facilities. To do so would create a permanent double standard under which some older facilities would continue indefinitely to be rewarded for their previous inappropriate billing. We note that even the statutory provision under section 404(a) of BIPA was set for a limited 2-year time period.

Comment: One commenter suggested that grandfathering be provided for all hospital facilities for which affirmative determinations of provider-based status had been made by CMS (previously, HCFA) before October 1, 2000, or that such facilities be presumed to meet the provider-based criteria in the revised regulations without having to attest to compliance with those criteria, so that any future determination that a facility is not provider-based would be applied on a prospective basis only.

Response: For the reasons noted above, we do not believe a general grandfathering of facilities is appropriate. In addition, the criteria in the program memorandum and instructions in effect before October 1, 2000, differ from the new proposed rules to be effective on October 1, 2002. Therefore, we do not believe it is appropriate to assume that facilities that received a provider-based determination under a prior set of criteria meet the new set of provider-based criteria in this final rule. Regarding the recommendation that any revised determination be made effective on a prospective-only basis, we note that, under § 413.65(c)(2), providers that have received affirmative determinations of provider-based status with respect to facilities or organizations are required to report material changes in the relationships between themselves and any provider-based facility or organization. A provider having a determination of provider-based status will need to comply with this rule and, in particular, as stated in revised § 413.65(l)(1), will need to report any aspect of its ownership or operation of the facility that it reasonably believes might not meet applicable provider-based requirements, to ensure that any redeterminations are made effective only prospectively.

Accordingly, we are adopting as final the proposed revision to § 413.65(b)(2), with a further clarification in response to a comment that the grandfathering provision applies to the requirements, limitations, and exclusions of § 413.65 (d), (e), (f), (h), and (i) only.

c. Revision of Application Requirement

Existing regulations at § 413.65(b)(2) establish an explicit application requirement for all facilities seeking provider-based status, except for grandfathered facilities and those treated as provider-based pending a determination on an application filed on or after October 1, 2000, and before October 1, 2002. Under existing § 413.65(b)(3), a main provider or a facility must contact CMS, and the facility must be determined by CMS to be provider-based, before the main provider bills for services of the facility as if the facility were provider-based, or before it includes costs of those services on its cost report. Many providers and provider representatives have expressed concern that the requirement to file an application will increase paperwork burden for hospitals unnecessarily. In response to these concerns, in the May 9, 2002 proposed rule, we proposed to revise the application requirements as follows:

First, we proposed to delete the existing application requirement under § 413.65(b)(3). We proposed to revise this section to state that except where payment is required to be made under BIPA, as specified in proposed revised § 413.65(b)(2) and (b)(5), if a potential main provider seeks an advance determination of provider-based status for a facility that is located on the main campus of the potential main provider, the provider would be required to submit an attestation stating that its facility meets the criteria in § 413.65(d) and, if it is a hospital, also attest that its facility will fulfill the obligations of hospital outpatient departments and hospital-based entities, as described in proposed § 413.65(g). We also proposed to require the provider to maintain documentation of the basis for its attestations and to make that documentation available to CMS upon request. We noted that, under this proposal, there would no longer be an explicit requirement that a provider-based approval be obtained before a facility is treated as provider-based for billing or cost reporting purposes. It

could benefit the provider to obtain a determination because, under the proposed § 413.65(l)(1) treatment of a facility as provider-based would cease only with the date that CMS determines that the facility no longer qualifies for provider-based status, if the reason the provider-based criteria are not met is a material change in the provider-facility relationship that was properly reported to CMS. By contrast, a provider which did not seek such a determination or obtained a determination but failed to report a material change in its relationship with the facility, could face a partial recovery of past payments. Also, under proposed § 413.65(j) (Inappropriate treatment of a facility or organization as provider-based) a provider that does not seek a provider-based determination and incorrectly bills as such could be subject to the partial recovery of payments for all cost reporting periods subject to reopening in accordance with §§ 405.1885 and 405.1889. We further proposed that if the facility is not located on the main campus of the potential main provider, the provider that wishes to obtain an advance determination of provider-based status would be required to submit an attestation stating that its facility meets the criteria in proposed revised §§ 413.65(d) and (e) and, if the facility is operated as a joint venture or under a management contract, the requirements in proposed §§ 413.65(f) and (h), as applicable. If the potential main provider is a hospital, the hospital also would be required to attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in proposed revised § 413.65(g). The provider seeking such an advance determination would be required to supply documentation of the basis for its attestations to CMS at the time it submits its attestations. We believe the use of an attestation process would strike an appropriate balance between the legitimate interests of hospitals in reducing paperwork and reporting, and the equally legitimate need of CMS to ensure proper accountability for compliance with the qualification requirements for a status that typically leads to a higher level of Medicare or Medicaid payment.

We noted that, under the proposed revisions to the application procedures at § 413.65(b), a hospital would not be explicitly required to submit an application and receive a provider-based determination for a facility before the time at which the hospital may bill for services at that facility as provider-based. However, we indicated that, alternatively, we would consider retaining the existing regulations at § 413.65(b)(2) which state that, except where payment is required to be made under BIPA as specified in proposed revised §§ 413.65(b)(2) and (b)(5), hospitals are explicitly required to submit provider-based applications, and to withhold billing as provider-based until CMS determines that a facility meets the provider-based rules. In the May 9, 2002 proposed rule, we specifically solicited comments on the appropriateness of this or other alternative application procedures.

Comment: Some commenters stated that although it appears that the mandatory application requirement under the existing regulations has been replaced with the voluntary attestation process, the preamble of the May 9, 2002 proposed rule made several references to procedures for applying for provider-based status. The commenters stated that if such references to an application in the final rule must be maintained in order to deal with applications submitted prior to the creation of the attestation process, such references should be clarified accordingly.

Response: While we have proposed to replace the mandatory requirement for provider-based determinations under existing § 413.65(b) with a voluntary attestation process, we note that providers still have the option of obtaining a determination of provider-based status for their facilities, which we encourage. The proposed method for doing so is through the attestation process. Under § 413.65(b)(3), the provider may obtain a determination of provider-based status by submitting an attestation stating that the facility meets the relevant provider-based requirements (depending on whether the facility is located on campus or off campus).

As we stated in the May 9, 2002 proposed rule (67 FR 31481), ''Until a uniform application is available, at a minimum, the request should include the identity of the main provider and the facility or organization for which provider-based status is being sought and supporting documentation for purposes of applying the provider-based status criteria in effect at the time the application is submitted.'' For purposes of this final rule, we are clarifying that, effective October 1, 2002, an attestation of provider-based status has the same effect as a request for provider-based status, in that approval of an attestation would result in a determination that a facility or organization is provider-based. Prior to October 1, 2002, the effective date of the final rule (or, in the case of grandfathered facilities, prior to the start of the provider's first cost reporting period beginning on or after July 1, 2003), the provider would submit a request for provider-based determination (as opposed to an attestation). (Until the effective date of these regulations on October 1, 2002, providers should contact their CMS Regional Offices for information regarding application procedures). For providers wishing to obtain a provider-based determination after October 1, 2002, the providers would submit an attestation to CMS. Accordingly, until a uniform request or attestation form is available, at a minimum, the provider should include the identity of the main provider and the facility or organization for which provider-based status is being sought and supporting documentation for purposes of applying the provider-based status criteria in effect at the time the request or attestation is submitted. The provider must also enumerate each facility and state its exact location (that is, its street address and whether it is on campus or off campus) and the date on which the facility became provider-based to the main provider. Documentation in support of the attestation of provider-based status must be submitted with the attestation for facilities located off campus. Main providers that submitted a request for a provider-based determination after October 1, 2000, but prior to the publication of this final rule, would be protected under section 404(c) of BIPA from recovery of overpayments in periods prior to the date on which CMS determines a facility is not provider-based.

We note that even though we proposed to remove the current general requirement that a determination of provider-based status be obtained, we did not propose to revise paragraph (n) of § 413.65 (redesignated in this final rule as paragraph (o)). That paragraph states that provider-based status cannot be effective before the earliest date on which a request for provider-based status has been made and all requirements of 42 CFR Part 413 have been met. To avoid creating confusion for providers and contractors and to allow the regulations to be implemented properly, we are making a conforming change to paragraph (o) to eliminate any reference to a mandatory application or determination, with one exception. As explained later in this preamble, we also state in § 413.65(o) that if a facility or organization is found by CMS to have been inappropriately treated as provider-based under paragraph (j) for certain time periods, or previously was

determined by CMS to be provider-based but no longer qualifies as provider-based because of a material change occurring during those periods that was not reported to CMS, CMS will not treat the facility or organization as provider-based for payment until CMS has determined, based on documentation submitted by the provider, that the facility or organization meets all requirements for provider-based status under Part 413.

Comment: One commenter stated that the proposed rules do not appear to provide hospitals that submit an attestation with any benefit with respect to recoupment of overpayments. For example, the commenter stated that, under the proposed rule, a provider could submit an attestation and begin providing and billing for provider-based services for years before receiving a determination from CMS that it is not provider-based and consequently be subject to the recovery of payments if CMS later determines that the facility is not provider-based. The commenter requested that a provider that submits a complete attestation not be liable for recovery of overpayments, but rather it should only be improper to bill as provider-based subsequent to a determination by CMS that a facility is not provider-based. Another commenter expressed concerns about possible long delays by CMS in reaching decisions on attestations and recommended that CMS require its regional offices to approve or disapprove provider-based status for each facility within 60 days after having received the attestation regarding that facility. Another commenter stated that it would like a written response to the attestations and accompanying documentation from CMS for the providers to keep on file.

Response: We do not agree that it would be appropriate to allow a provider that has attested inaccurately to being provider-based to retain payments made to the provider as if the facility were in full compliance with provider-based criteria. However, CMS would not recover all past payments for periods subject to reopening, but instead would recover only the difference between the amount of payment that actually was made since the date the complete request for a provider-based determination was submitted and the amount of payments that CMS estimates should have been made in the absence of compliance with the provider-based requirements. At the time that CMS determines that a facility that submitted a complete attestation is actually not provider-based, payment would continue for up to 6 months but only at a reduced rate as described at § 413.65(j)(5).

Regarding the timeliness of action on attestations, we agree that providers should not be subject to long delays before action is taken. In response to this and other comments requesting further information on the procedures CMS will follow when an attestation is received, we are revising § 413.65(b)(3) by adding new paragraphs (iii) and (iv). In new paragraph (b)(3)(iii), we are clarifying that whenever a provider submits an attestation of provider-based status for an on-campus facility or organization, CMS will send the provider written acknowledgement of receipt of the attestation, review the attestation for completeness, consistency with the criteria in § 413.65, and consistency with information in the possession of CMS at the time the attestation is received, and make a determination as to whether the facility is provider-based. In new paragraph (b)(3)(iv), we are clarifying that whenever a provider submits an attestation of provider-based status for an off-campus facility or organization, CMS will send the provider written acknowledgement of receipt of the attestation, review the attestation for completeness, consistency with the criteria in § 413.65, consistency with the documentation submitted with the attestation, and consistency with information in the possession of CMS at the time the attestation is received, and make a determination as to whether the facility is provider-based.

We also will work with our regional offices and intermediaries as necessary to ensure that providers that submit attestations receive a prompt response. However, because of workload considerations and uncertainty about the volume of attestations that may be received, we have not yet specified a timeframe for completion of action on an attestation.

Comment: One commenter recommended that if CMS finds an attestation to be incomplete, the provider be given an additional 30 days to submit supplementary information in support of the attestation.

Response: We agree that providers who inadvertently omit needed information from an attestation should be given a reasonable opportunity to supplement that information. However, at the same time, we agree with the commenters who pointed out the importance to the provider of receiving a timely decision on whether a particular facility qualifies for provider-based status. If CMS were to delay a decision for a provider that repeatedly submitted incomplete attestations, this would prevent a timely response and could defeat the purpose of the attestation procedure. We intend to develop further implementing instructions and procedures that will strike a reasonable balance between the need for additional information and the need for a timely decision.

Comment: One commenter requested that we reiterate that, since providers are no longer required under the proposed revised regulations to submit an attestation or an application for provider-based status as a precondition to billing for provider-based services, CMS would only consider a provider to be billing inappropriately if the provider was wrong in its conclusion that it meets the provider-based requirements. The commenter also asked that we clarify that facilities grandfathered under BIPA also need not submit an attestation, even at the expiration of the grandfathering period. Facilities grandfathered by BIPA will be treated the same as all other facilities on the date that their grandfathering period expires, which is the start of the cost reporting periods that begin on or after July 1, 2003.

Response: The commenter is correct in the view that providers, regardless of whether they are grandfathered under BIPA, are not obligated to submit attestations or applications for provider-based status before they begin billing as provider-based, and that a provider would only be considered to be billing inappropriately if the facility actually did not meet the relevant provider-based rules. However, we note that if a provider does not submit a complete attestation of provider-based status, and CMS subsequently determines that the provider is billing inappropriately, the provider would be subject to recovery of overpayments under § 413.65(j)(ii) for services at that facility(ies) for all prior cost reporting periods subject to reopening in accordance with §§ 405.1885 and 405.1889.

Comment: One commenter noted that all hospitals, even those previously subject to grandfathering, will be subject to the new regulations as of their first cost reporting periods starting on or after July 1, 2003. In view of this obligation, the commenter believed that it is unnecessary for attestations to be submitted for any facilities that are located on the campus of the hospital that claims them as provider-based. The commenter also recommended that if CMS later determines that the facility does not meet the provider-based criteria, CMS should not recover any past payments attributable to improper billing, but apply its determination only prospectively.

Response: As explained more fully earlier in this preamble, under these final rules, while the provider-based criteria must be met, no provider is required to submit an attestation for any facility as a precondition to billing for its services as a provider-based facility. This is the case even where the facility is located on the main campus of a hospital. However, we believe an attestation has value, in that a provider that makes such an attestation presumably does so after having reviewed the provider-based criteria and assessed a particular facility's structure and operations in relation to them. Moreover, the attestation relates to compliance with only a minimal level of integration, and does not require any supporting documentation. Therefore, we do not believe that providing an attestation will require an unreasonable level of effort from the provider.

Comment: One commenter recommended that off-campus facilities be required to submit attestations of compliance with the provider-based criteria before the date on which the revised regulations become effective for them. (For grandfathered facilities, §§ 413.65(d), (e), (f), (h), and (i) of the revised regulations would become effective for the hospital's first cost reporting period starting on or after July 1, 2003.) The commenter also recommended that if these facilities are later found not to have met the provider-based requirements, any determination that they are not provider-based should be applied only prospectively.

Response: As explained in response to a previous comment, we cannot agree that a provider should be allowed to retain payments made as if a facility were provider-based after a determination has been made that the provider-based criteria were not met. Therefore, this final rule provides for recovery of past payments to the extent necessary to make those payments relate more closely to what would have been paid if the facility's services had been billed on a freestanding basis.

Comment: One commenter expressed approval of our proposal under which supporting documentation would not have to be submitted with the attestation for on-campus facilities. The commenter suggested that the paperwork burden for providers could be further reduced if the regulations were revised to eliminate the need for supporting documentation for attestations regarding off-campus facilities or organizations as well. Another commenter stated that hospital-licensed community health centers frequently are located within a few miles of the main provider-campus and are closely integrated with it. The commenter believed these facilities should not be required to submit supporting documentation.

Response: We understand and share the commenters' interest in reducing the paperwork burden on providers. However, this important objective must be balanced against the equally important need to ensure proper accountability by providers for the status of the facilities or organizations for which they are claiming provider-based status. Determining whether an off-campus facility is truly integrated with a main provider is more difficult than for a facility located on the main campus of a provider, and this is why there are additional requirements for off-campus facilities to demonstrate provider-based status. In view of this, we believe it is reasonable to require that an attestation regarding an off-campus facility, including hospital-licensed community health centers, be accompanied by supporting documentation that clearly shows the basis for the attestation.

Comment: One commenter noted that proposed § 413.65(b)(3)(i) requires a provider that makes a provider-based attestation with regard to an on-campus facility to make documentation supporting that attestation available to CMS upon request. The commenter recommended that the regulation be revised to require that the supporting documentation also be made available to CMS contractors (fiscal intermediaries and carriers) upon request. *Response:* We agree, and are revising the final rule accordingly.

Comment: One commenter asked CMS to provide guidance as to the type of documentation that is required to be submitted with an attestation for an off-campus facility. Another commenter suggested that before a uniform application is available, providers should be required to submit information regarding physical location, a contact person, and the date the facility became provider-based to the main provider.

Response: As stated above, until a uniform attestation form is available, at a minimum, the attestation should include the identity of the main provider and the facility(ies) or organization(s) for which provider-based status is being sought and supporting documentation for purposes of applying the provider-based status criteria in effect at the time the application is submitted. The provider must also enumerate each facility and state its exact location (that is, its street address and whether it is on campus or off campus) and the date on which the facility became provider-based to the provider. We plan on issuing further guidance in program instructions after publication of this final rule.

Comment: One commenter noted CMS' authority to terminate payment prospectively if a provider fails to provide all necessary information as part of the continuation of payment provisions under § 413.65(j)(5). Given this authority, and because the commenter believed it will be difficult for providers to know what constitutes a complete attestation, the commenter recommended that CMS provide the opportunity for providers to supplement their original submissions with additional information within 30 days of receipt of notice from CMS that the submission is incomplete.

Response: Under § 413.65(b)(3), a complete request (or attestation) is one that includes all information needed to permit CMS to make a determination. We have stated above that we plan to issue further guidance as to what information should be included in an attestation. However, we note that, under § 413.65(j)(5), a provider must notify CMS in writing within 30 days of the date that CMS issues its denial of provider-based status, of whether the provider intends to seek a determination of provider-based status for the facility or whether the practitioners will be seeking to enroll to bill Medicare or Medicaid for services at that location as a freestanding facility. If the provider notifies CMS of its intentions within 30 days, the provider has up to 6 months to take whatever steps are necessary to comply with the relevant rules, whether that means providing CMS with supplemental documentation or making changes to meet the regulatory requirements (for example, a provider is renegotiating its management contracts). Therefore, we believe it is unnecessary to add an additional 30 days to the interim period in which payment continues at a reduced rate.

Comment: One commenter asserted that if CMS has concerns about the status of on-campus facilities, it should be incumbent on CMS to initiate an investigation and to provide notice to the provider and opportunity for the facilities to fix any discrepancies prior to losing provider-based status. The commenters added that it is still unclear whether every service on the hospital's campus would need to submit an attestation, or if one attestation is sufficient to cover all on-campus facilities. Some commenters also asked whether, and in what timeframe, these sites will receive a written response from CMS.

Response: We do not agree with this commenter's suggestion that providers that have been inappropriately treating certain facilities as provider-based and have not attempted to obtain a provider-based determination should be protected from recovery of past overpayments. However, we note that § 413.65(j)(5) of this final rule would allow such a provider up to 6 months of continued payment, at an adjusted rate, to meet applicable billing requirements.

In regard to the commenter's request for clarification concerning whether every service on the hospital's campus would need to submit an attestation, or if one attestation is sufficient to cover all on-campus facilities, we emphasize that the provider-based rules do not apply to specific services; rather, these rules apply to facilities as a whole. That is, the facility in its entirety must be a subordinate and integrated part of the main provider. For example, a provider may have several outpatient facilities, some located on campus and some located off campus, yet each facility as a whole must meet the applicable rules for provider-based status. However, a main provider would not need to submit a separate application for each one of its facilities for which a provider-based determination is sought. A provider may attest in a single application package that each one of its facilities in which it intends to bill for services as if the facility is provider-based meets the applicable provider-based rules under § 413.65. For those facilities that are located on campus, no documentation is required to be submitted with the attestation. Documentation must be submitted for those facilities located off campus. However, we are requiring that as part of its attestation, the main provider enumerate each facility and state its exact location (that is, its street address and whether it is on campus or off campus).

As noted earlier, the commenters also asked whether, and in what timeframe, a provider that submits an attestation will receive a written response from CMS. While we are making revisions in these final rules to provide more information about the actions CMS will take in response to such an attestation, at this time, due to the uncertainty of the volume of requests that will be submitted by providers, we cannot state an exact timeframe in which the provider-based determinations will be made for on-campus or off-campus facilities. Each attestation will be received and processed by the appropriate CMS Regional Office (or fiscal intermediary) and will be reviewed as soon as possible.

Comment: One commenter asked if a ''re-attestation'' is required after a certain period of time.

Response: Just as providers are no longer explicitly required to submit an initial attestation, there is also no explicit requirement for hospitals to re-attest that their facilities continue to meet the provider-based requirements. However, we note that, under proposed § 413.65(k) (revised as § 413.65(l) in this final rule), if CMS determines that a facility that had previously been determined to be provider-based no longer qualifies for provider-based status, and the failure to qualify for provider-based status results from a material change in the relationship between the main provider and the facility that the main provider *did* report to CMS, treatment of the facility as provider-based would cease with the date that CMS determines that facility no longer qualifies for provider-based status. Conversely, if a main provider *did not* report a material change to CMS, the main provider will be subject to recovery of overpayments as described under § 413.65(j)(1)(ii).

Comment: One commenter stated that the use of the term ''advance determination'' is confusing because the rule does not provide for an advance determination of provider-based status.

Response: We agree with the commenter and are removing all references to ''advance'' used in connection to provider-based determinations from this final rule. We note that, under proposed § 413.65(k) (revised as § 413.65(l) in this final rule), a provider that submits a complete attestation of compliance with the provider-based status requirements for a facility that has not previously been found by CMS to have been inappropriately treated as provider-based, may bill and be paid for services of the facility as provider-based from the date of its attestation of provider-based status until the date that CMS determines that the facility is not provider-based.

Accordingly, we are adopting as final the proposed changes to § 413.65(b)(3) with the following modifications: We are revising § 413.65 by adding new paragraphs (b)(3)(iii) and (iv) to include further information on procedures for submitting and processing attestations; removing references to the term ''advance'' in connection with determinations in paragraphs (b)(3)(i) and (ii); and adding language under paragraph (b)(3)(i) regarding the availability of documentation to contractors.

d. Requirements Applicable to All Facilities or Organizations

Under existing § 413.65, all facilities seeking provider-based status with respect to a hospital or other main provider must meet a common set of requirements. These include requirements relating to common licensure (paragraph (d)(1)), operation under the ownership and control of the main provider (paragraph (d)(2)), administration and supervision (paragraph (d)(3)), integration of clinical services (d)(4)), financial integration (paragraph (d)(5)), public awareness (paragraph (d)(6)), and location in the immediate vicinity of the main provider (paragraph (d)(7)). (In addition, as described more fully below, specific rules applicable to all facilities rule out provider-based status for facilities operated as joint ventures by two or more providers (paragraph (e)) and limit the types of management contracts that facilities seeking provider-based status may operate under (paragraph (f)).)

Since publication in final of the existing provider-based rules in April 2000, hospitals and other providers have expressed concern that the requirements outlined above are overly restrictive and do not allow them enough flexibility to enter into appropriate business arrangements with other facilities. We understand these concerns, and agree that Medicare rules should not restrict legitimate business arrangements that do not lead to abusive practices or disadvantage Medicare beneficiaries. At the same time, we believe our existing rules provide a high level of assurance that a facility complying with them is, in fact, an integral and subordinate part of the facility with which it is based, and do not accord provider-based status to facilities that are not integral and subordinate to a main provider, but in fact have only a nominal relationship with that provider.

After considering all comments received on these issues, we believe that further changes in the provider-based rules would be appropriate. In particular, we agree with those who argue that a facility's or organization's location relative to the main campus of the provider is relevant to the integration that is likely to exist between the facility or organization and the main provider. For example, if a facility or organization is located on the main campus of a provider, is operated under the main provider's State license, is medically and financially integrated with that provider, and is held out to the public and other payers as a part of that provider, we believe the necessary

degree of integration of the facility or organization into the main provider can be assumed to exist. We also are concerned that further prescribing the types of management contracts or other business arrangements that may exist between the main provider and the facility or organization would unnecessarily restrict its flexibility to establish cost-effective agreements without significantly enhancing the integration of the facility or organization into the main provider. Therefore, in the May 9, 2002 proposed rule, we proposed to simplify the requirements applicable to facilities or organizations located on the campus of the main provider (as campus is defined in existing regulations at § 413.65(a)(2)). Under our proposal, all facilities seeking provider-based status, including both on-campus and off-campus facilities, would be required to comply with the existing requirements regarding licensure, clinical services integration, financial integration, and public awareness. (These requirements are currently codified at §§ 413.65(d)(1), (d)(4), (d)(5), and (d)(6) and were proposed to be redesignated as paragraphs (d)(1) through (d)(4), respectively, of § 413.65.)

With respect to financial integration, existing regulations at § 413.65(d)(5) require that the financial operations of the facility or organization be fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The regulations also require that costs of a provider-based facility or organization be reported in a cost center of the provider, and that the financial status of any provider-based facility or organization be incorporated and readily identified in the main provider's trial balance.

Some hospital representatives have questioned the appropriateness of requiring that the costs of a remote location of a hospital be reported in a single cost center, noting that such costs ordinarily would appear in multiple cost centers of the main provider, with (for example) employee health and welfare costs of the remote location being included in the corresponding cost center of the main provider. In recognition of this concern, in the May 9, 2002 proposed rule, we proposed to revise the requirement to state that the costs of a facility or organization that is a hospital department must be reported in a cost center of the provider, and that costs of a provider-based facility or organization other than a hospital department must be reported in the appropriate cost center or cost centers of the main provider.

Paragraph (d) of § 413.65 was proposed to be retitled ''Requirements applicable to all facilities or organizations'' and, as indicated by its revised title, would set forth those core requirements that any facility or organization would have to meet to qualify for provider-based status.

We proposed to delete from this paragraph (d) the requirements in existing paragraphs (d)(2) and (d)(3) relating to operation under the ownership and control of the main provider and administration and supervision because we proposed to no longer apply these requirements to on-campus facilities or organizations. These requirements would be moved to paragraph (e) as described below to reflect the proposed limitation of their applicability to off-campus departments. The core requirements for all facilities or organizations, including facilities located on campus, also would not include the requirement regarding location in the immediate vicinity of the main provider (existing § 413.65(d)(7)). Because any facilities or organizations located on the campus of the main provider automatically meet the requirement regarding location in the immediate vicinity (existing § 413.65(d)(7)), the requirement is only of relevance to off-campus facilities or organizations. For clarity, we proposed to relocate the requirement to paragraph (e) as described below.

We also proposed to require, in paragraph (d)(5) of § 413.65, all hospital outpatient departments and hospital-based entities, including those located on campus and those located off the campus of the main provider hospital, to fulfill the obligations currently codified and proposed to be retained at § 413.65(g) in order to qualify for provider-based status. (Fulfillment of these obligations is currently required under § 413.65(g).) As explained further below, we also proposed other changes to paragraph (g).

We did not receive any comments on these proposed changes. Therefore, in this final rule, we are adopting the proposed changes as final.

e. Additional Requirements Applicable to Off-Campus Facilities or Organizations

We recognize that facilities or organizations located off the main provider campus may also be sufficiently integrated with the main provider to justify provider-based designation. However, the off-campus location of the facilities or organizations may make such integration harder to achieve than for on-campus facilities or organizations, and such integration should not simply be presumed to exist. Therefore, to ensure that off-campus facilities or organizations seeking provider-based status are appropriately integrated, in the May 9, 2002 proposed rule, we proposed to retain certain requirements to demonstrate integration that we proposed to remove for on-campus facilities or organizations. These requirements were set forth in proposed new § 413.65(e). The requirements set forth in proposed paragraphs (e)(1), (e)(2), and (e)(3) included the requirements on operation under the ownership and control of the main provider (existing § 413.65(d)(2)), administration and supervision (existing § 413.65(d)(3)), and location (existing § 413.65(d)(7)).

We did not receive any comments on these proposed changes. Therefore, in this final rule, we are adopting the proposed changes as final.

f. Joint Ventures

Consistent with our views as expressed earlier in this preamble regarding the assumption that a higher degree of integration can be presumed for on-campus facilities or organizations and in recognition of the need to promote reasonable cooperation among providers and avoid costly duplication of specialty services, in the May 9, 2002 proposed rule, we proposed to revise the regulations on joint ventures (currently set forth under § 413.65(e)) to limit their scope to facilities or organizations not located on the campus of any potential main provider. Specifically, we proposed to redesignate § 413.65(e) as § 413.65(f) and revise it to state that a facility or organization that is not located on the campus of the potential main provider cannot be considered provider-based if the facility or organization is owned by two or more providers engaged in a joint venture. We also proposed to make minor changes to the second sentence of the redesignated paragraph (f) to clarify its meaning.

Comment: One commenter noted that proposed § 413.65(f) states that facilities or organizations operated by two or more providers engaged in a joint venture cannot be considered provider-based if they are not located on the campus of the potential main provider. The commenter believed that the rule would be more easily understood if paragraph (f) were revised to state that a facility or organization owned by two or more providers engaged in a joint venture cannot be considered provider-based unless it is located on the campus of at least one of the providers engaged in the joint venture.

Response: We agree that clarification of the joint venture requirements is needed. Therefore, in this final rule we are revising § 413.65(f) to clearly state that, in order for a facility or organization operated as a joint venture to be considered provider-based, it must (1) be partially owned by at least one provider; (2) be located on the campus of a provider who is a partial owner; (3) be provider-based to that one provider whose campus on which the facility or organization is located; and (4) meet all of the requirements applicable to all provider-based facilities and organizations in § 413.65(d). Therefore, to be treated as provider-based, the facility operated as a joint venture must be provider-based to the provider whose campus on which the facility is located, regardless of whether that provider is the majority owner.

For example, if Hospital A owns 60 percent of Facility C and Hospital B owns 40 percent of Facility C, but Facility C is located on the campus of Hospital B, Facility C may only be provider-based to Hospital B.

Comment: One commenter asked if the provider where the service is located has to be the billing provider of the joint venture. The commenter also had questions about the rules concerning public awareness and other criteria as they relate to a joint venture service. The commenter asked whether the facility had to advertise as a joint venture, as a service of the provider where the site is located, or as a service of the billing provider.

Response: As we explained in the response to the previous comment, the facility owned by a joint venture must be provider-based to the provider whose campus on which the facility is located, regardless of whether that provider is the majority owner. The main provider does not have to advertise as a joint venture, but as a facility that is provider-based to the main provider. Accordingly, the services in the facility would be billed using the provider number of the provider whose campus on which the facility is located. (The facility cannot, of course, be provider-based with respect to both hospitals.) In addition, the facility owned by a joint venture must also meet all the requirements applicable to all provider-based facilities in § 413.65(d).

Comment: Some commenters requested that CMS allow facilities owned by a joint venture but not located on a hospital's campus to be considered provider-based. The commenters stated that joint ventures among and between hospitals in rural areas greatly help to improve access to care.

Response: While it is not our intent to limit access to care, we continue to believe that facilities owned by joint ventures that are not located on a main provider's campus do not qualify as provider-based. Thus, we are not adopting the commenter's request.

Accordingly, we are adopting as final the proposed § 413.65(f), with clarifying changes to the criteria for being determined a joint venture as discussed under the responses to comments.

g. Clarification of Obligations of Hospital Outpatient Departments and Hospital-Based Entities

Existing regulations impose specific obligations for hospital outpatient departments and hospital-based entities, but do not specify the sanction that applies if the facility or organization does not fulfill its obligations. To clarify policy on this issue and emphasize the importance of compliance with the requirements in this area, in the May 9, 2002 proposed rule, we proposed to revise existing § 413.65(g) to state that to qualify for provider-based status in relation to a hospital, a facility or organization must comply with these requirements. In regard to these obligations, we proposed to make three changes in existing § 413.65(g). First, we proposed to revise paragraph (g)(1) by deleting the second sentence of that paragraph. In paragraph (g)(2), we proposed to delete the reference to site-of-service reductions and instead refer to more accurately determined physician payment amounts, in order to more accurately describe how payment under the physician fee schedule is determined. In addition, we proposed to revise the first sentence of paragraph (g)(7) to clarify that the notice requirements in it do not apply where a beneficiary is examined or treated for a medical condition in compliance with the antidumping rules in § 489.24. We believed that this clarification was needed because we believe it would be a violation of the antidumping requirements if examination or treatment required under § 489.24 was delayed in order to permit notification of the beneficiary or the beneficiary's authorized representative. Further, we proposed to revise § 413.65(g)(7) to state that notice is required once the beneficiary has been appropriately screened and the existence of an emergency has been ruled out or the emergency condition has been stabilized.

We did not receive any comments on these proposed changes to § 413.65(g)(2) and (g)(7). Therefore, in this final rule, we are adopting the proposed changes as final

With regard to the proposed changes to § 413.65(g)(1), although we stated above that we are planning to finalize EMTALA policy proposed on May 9, 2002 in a separate document to be published shortly, we are adopting as final the proposed change concerning the applicability of EMTALA to provider-based entities located on the hospital main campus. Currently, under § 413.65(g)(1), if any individual comes to any hospital-based entity (including an RHC) located on the hospital main campus and a request is made on the individual's behalf for examination or treatment of a medical condition, the entity must comply with the antidumping rules at § 489.24. We stated in the proposed rule (67 FR 31477) that, since provider-based entities, as defined in § 413.65(b), are not under the certification and provider number of the main provider hospital, this language, read literally, would appear to impose EMTALA obligations on providers other than hospitals, a result that would not be consistent with section 1867 of the Act, which restricts EMTALA applicability to hospitals. To avoid confusion on this point and the extension of EMTALA requirements to other nonhospital providers, we are clarifying at § 413.65(g)(1) that EMTALA applies in this scenario to only those departments on the hospital's main campus that are provider-based. Accordingly, EMTALA does not apply to provider-based entities (such as RHCs) that are either on or off the hospital campus.

Because we received no public comments on this proposed clarification on the applicability of EMTALA to provider-based entitles, we are adopting as final this one change at § 413.65(g)(1) by deleting the second sentence at existing § 413.65(g)(1) that addresses this policy. However, we note again that in this final rule we are not adopting other clarifications in the proposed rule concerning application of EMTALA to provider-based departments, on or off the campus, or any other proposals concerning EMTALA. We received over 600 pieces of correspondence on these subjects. In order to give proper consideration to these comments, we plan to issue a final policy on the EMTALA proposals in a separate document.

h. Management Contracts

Under existing regulations, facilities or organizations operated under management contracts may be considered provider-based only if they meet specific requirements in § 413.65(f) (proposed in the May 2002 proposed rule to be redesignated as § 413.65(h)).

In particular, staff of the facility or organization, other than management staff, may not be employed by the management company but must be employed either by the provider or by another organization, other than the main provider, which also employs the staff of the main provider. Under existing regulations, these requirements apply equally to on-campus and off-campus facilities or organizations.

Consistent with our intent to simplify provider-based requirements for on-campus facilities or organizations, we proposed to restrict the applicability of proposed redesignated paragraph (h) to off-campus facilities or organizations. In addition, we proposed two additional changes that we believe are needed to respond to questions that are raised frequently about the regulation. First, we proposed to specify that a facility or organization operated under a management contract may be considered provider-based only if the main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule established by regulations at 42 CFR Part 414. We did not propose to specify who may employ other support staff, such as maintenance or security personnel, and who are not directly involved in providing patient care, nor did we propose to require licensed professional caregivers such as physicians, physician assistants, or certified registered nurse anesthetists to become provider employees. We also proposed to revise the regulations to clarify at § 413.65(h)(2) that so-called ''leased'' employees (that is personnel who are actually employed by the management company but provide services for the provider under a staff leasing arrangement) are not considered to be employees of the provider for purposes of this provision.

Comment: One commenter supported the proposal eliminating restrictions on management contracts and joint ventures for on-campus facilities. The commenter also supported the modification to the management contract rules applicable to off-campus facilities that requires the main provider to employ only those staff who are directly involved in the delivery of patient care, other than staff who may be paid under the Medicare fee schedule, management staff, and other support staff. Another commenter recommended that CMS limit the management contract restrictions for off campus facilities by allowing the management company to employ at least some of the patient care staff at the facility, as long as the facility remains integrated with, and under the control of, the main provider.

Response: We agree with the commenter who stated that it is appropriate to require the main provider to employ only those staff who are directly involved in the delivery of patient care, other than staff who may be paid under the Medicare fee schedule, management staff, and other support staff. We considered the comment suggesting that the regulations be further changed to allow at least some of these staff to be provided under a management contract. However, we are not adopting this change. We note that the revisions in the proposed rule would have significantly relaxed the requirements relating to management contracts by restricting the scope of those provisions to off-campus facilities and by expanding the range of services that may be furnished under management contracts in those facilities. Under our proposal, even if only the services described in this comment would have to be furnished by the provider, the provider would be permitted to bill as if it delivered the services itself. If we were to further weaken the management contract requirements, this would remove any effective control on such contracts, thereby allowing the provider to claim provider-based payment for a facility with which it has only a contractual relationship. We believe such a tenuous connection between the provider and the facility does not warrant payment for the facility's services as services of an ''integral and subordinate'' part of the provider. Therefore, we are not adopting this comment.

Comment: One commenter recommended that inpatient facilities be exempted from the management contract requirements in proposed § 413.65(h).

Response: We note that our proposed rule accomplished much of what the commenter recommended, in that it would exempt on-campus facilities, including those facilities that treat a patient population made up largely or entirely of inpatients, from the management contract requirements in § 413.65(h). We are adopting this proposal without change in the final rule. However, for the reasons discussed earlier in responding to comments on the scope of the provider-based requirements, we do not believe it would be appropriate to exclude off-campus facilities and organizations from the management contract requirements.

Comment: One commenter recommended that CMS regional offices be authorized to exempt facilities or organizations from the management contract requirements on a case-by-case basis, depending on the circumstance in each case.

Response: We agree that regional offices need to exercise judgment in application of the criteria, but do not agree that the exercise of that judgment should include discretion to entirely waive applicability of a requirement. This could lead to wide variations in the applicability of the provider-based criteria in different areas of the country. Therefore, we are not making any change in the final rule based on this suggestion.

Comment: Some commenters requested clarification of the relationship between provision of services under management contracts and under arrangements of the kind described in section 1861(w)(1) of the Act. The commenters further recommended that proposed § 413.65(i), which states that a facility or organization cannot qualify for provider-based status if all services at the facility are furnished under arrangements, be revised so that it does not apply to on-campus facilities. The commenters expressed concern that if that change is not made, management contracts for on-campus facilities or organizations that are permitted under proposed §§ 413.65(d) and (h) would nevertheless be prohibited by § 413.65(i).

Response: Generally, we believe there is a substantial difference between the use of management contracts to obtain some or all input services needed to operate a health care facility, including not only management but professional and other staffing, security, maintenance, other support services, and the use of section 1861(w)(1) arrangements by a provider to obtain specialized health care services that it does not itself offer, and that are needed to supplement the range of services that the provider does offer its patients. In the first situation, it is possible that all or virtually all services needed to operate a facility could be obtained under contract, resulting in nothing more than a nominal connection between the facility and the provider that claims it as an integral and subordinate part. To prevent a facility operated in this way from inappropriately claiming to be part of a provider, reasonable controls on management contracts are needed. In the latter case, a provider may

legitimately obtain limited specific services under arrangements without sacrificing its ability to function independently as a provider and directly furnish care to its patients.

In this context, we would agree with the commenter that a provider that operates a facility that qualifies legitimately as provider-based may choose to obtain some specialized services for its patients under arrangements without needing to meet the management contract requirements of § 413.65(h) with respect to each individual service. As noted above, these requirements apply to facilities, not to individual services. However, we continue to believe it would be inappropriate for a facility, whether located on or off campus, to evade the provider-based requirements by claiming to provide all of its services under arrangements. Therefore, we are not making further changes to § 413.65(i).

Comment: One commenter stated that CMS' intentions were unclear in the proposed regulations at § 413.65(h)(1) that state, ''Leased employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) are not considered to be employees of the provider for purposes of this paragraph.'' The commenter added that it is unclear if this provision prohibits arrangements under which a management company employs clinical staff paid under a fee schedule that are subsequently leased to the main provider to provide services in the provider-based facility. The commenter suggested that we clarify this language and, in the final rule, state that the exception to the main provider employment requirement for patient care staff that furnish services paid for under a fee schedule also applies to leased employees from a management company.

Response: In the proposed rule, we stated that the main provider is required to employ only those staff who are directly involved in the delivery of patient care other than staff who may be paid under the Medicare fee schedule, management staff, and other support staff. Therefore, the main provider may not use ''leased'' employees if those employees are directly involved in delivering patient care and cannot be paid under the Medicare fee schedule. However, this provision would *not* prohibit arrangements under which a management company employs clinical staff who may be paid under a fee schedule that are leased to the main provider to provide services in the provider-based facility. The management company may otherwise employ and provide the staff who furnishes patient care services that may be paid for by Medicare under a fee schedule. Accordingly, as the commenter recommended, we are clarifying the regulations text to state that, other than staff that may be paid under a Medicare fee schedule, the main provider may not utilize the services of leased employees who are directly involved in patient care in off-campus facilities.

Comment: One commenter stated that the proposed regulation that would require the main provider to employ all staff who ''are directly involved in the delivery of patient care, except for management staff * * *'' is confusing, because in many instances, managers are involved both in management activities and in furnishing direct patient care.

Response: If these managers are also medical professionals who may receive payment for their patient care services under a Medicare fee schedule, they do not need to be employed directly by the main provider.

Comment: Some commenters stated that the prohibition of off-campus management contracts will have harmful consequences, particularly in areas where private hospitals have partnerships with local government to operate off-campus psychiatric facilities in remote, underserved areas. The commenter explained that the county government manages an off-campus psychiatric facility as an inpatient psychiatric unit of a private hospital, and that county employees provide all patient care services in the unit. Although the facility is currently grandfathered under section 404(a) of BIPA, the facility will be unable to qualify for provider-based status when the grandfathering period expires, resulting in a loss of essential mental health services to the surrounding communities. The commenters requested that counties that have partnerships with private entities in order to ensure access to care and meet all other provider-based criteria be exempted from the management contract prohibition.

Response: While we are sympathetic to the needs of the medically underserved, we do not believe the management contract requirements to be overly restrictive. Rather, we believe the employment of the staff of an off-campus facility is a significant factor in determining the degree to which a facility or department is integrated (that is, provider-based) with its parent hospital. This is particularly important in a facility operated under a management contract. Because such a facility already receives management (and typically, many other services and supplies) from the management company, employment of the caregivers by the provider provides a strong link to the provider's other operations and demonstrates that the facility continues, despite the purchase of management services under contract, to be an integral and subordinate part of the provider. As such, we do not believe that it is appropriate to exempt any off-campus facilities from the management contract requirement.

Accordingly, we are adopting as final the proposed § 413.65(h) with one change to paragraph (h)(1) to clarify use of leased employees by a provider as discussed in the response to comments.

i. Inappropriate Treatment of a Facility or Organization as Provider-Based

Below we describe the steps that we would take if we discover that a facility is billing as provider-based without having requested a determination or having submitted a complete attestation regarding provider-based status as described earlier, or if the facility received a provider-based determination but the main provider did not inform CMS of a subsequent material change that affected the provider-based status of its facility.

(1) Inappropriate billing

The existing regulations at § 413.65(i) state that if we discover that a provider is billing inappropriately, we will recover the difference between the amount of payments that actually were made and the amount of payments that CMS estimates should have been made in the absence of a determination of provider-based status. Existing § 413.65(j)(2) states that we would adjust future payments to estimate the amounts that would be paid, in the absence of a provider-based determination, if all other requirements for billing are met. In addition, existing § 413.65(j)(5) describes a procedure under which CMS would continue payments to a provider for services of a facility or organization that had been found not to be provider-based, at an adjusted rate calculated as described in existing paragraph (j)(2), for up to 6 months in order to permit the facility or organization adequate time to meet applicable enrollment and other billing requirements. While CMS is not legally obligated to continue payments in this matter, we believe it would be appropriate to do so, on a time-limited basis, to allow for an orderly transition to either provider-based or freestanding

status for the facility and to avoid disruption in the delivery of services to patients, particularly Medicare patients, who may be relying on the facility for their medical care.

In the May 9, 2002 proposed rule, we proposed to adopt a policy concerning recoupment and continuation of payment that closely parallels the policy stated in existing regulations at § 413.65(j). Under proposed § 413.65(j)(1), if CMS learns that a provider has treated a facility or organization as provider-based and the provider did not request an advance determination of provider-based status from CMS under proposed § 413.65(b)(3), and CMS determines that the facility or organization did not meet the requirements for provider-based status under proposed § 413.65(d) through (i), as applicable (or, in any period before the effective date of these regulations, the provider-based requirements in effect under Medicare program regulations or instructions), CMS would take several actions. First, we proposed to issue notice to the provider, in accordance with proposed paragraph (j)(3), that payments for past cost reporting periods may be reviewed and recovered as described in proposed paragraph (j)(2)(ii), that future payments for services in or at the facility or organization will be adjusted as described in proposed paragraph (j)(4), and that continued payments to the provider for services of the facility or organization will be made only in accordance with proposed paragraph (j)(5). In addition, we proposed (proposed § 413.65(j)(1)(ii)) that CMS would, except for providers protected under section 404(a) or (c) of BIPA (implemented at § 413.65(b)(2) and (b)(5)) or the exception for good faith effort at existing § 413.65(i)(2) and (i)(3)), recover the difference between the amount of payments that actually was made to that provider for services at the facility or organization and an estimate of the payments that CMS would have made to that provider for services at the facility or organization in the absence of compliance with the requirements for provider-based status. We proposed to make recovery for all cost reporting periods subject to reopening in accordance with §§ 405.1885 and 405.1889. Also, we proposed to adjust future payments to estimate the amounts that would be paid for the same services furnished by a freestanding facility.

Recovery of past payments would be limited in certain circumstances. If a provider did not request a provider-based determination for a facility by October 1, 2002, but is included in the grandfathering period under § 413.65(b)(2), we proposed to recoup all payments subject to the reopening rules at §§ 405.1885 and 405.1889, but not for any period before the provider's cost reporting period beginning on or after July 1, 2003.

Comment: One commenter stated that, under current policies, teaching hospitals may claim the time residents spend training at freestanding facilities (known as ''nonhospital sites'') only when there is a written agreement between the hospital and the nonhospital site. No written agreement is needed if the site is provider-based. The commenter asked that if CMS determines that a facility does not meet the provider-based rules, the indirect medical education (IME) payments that were received by the teaching hospital should not be affected.

Response: If CMS determines that a provider, whether teaching or nonteaching, is inappropriately receiving payment in a facility since the facility is determined not to be provider-based, CMS would take several actions, including, as described under § 413.65(j)(3), reviewing payments for past cost reporting periods in order to recover the difference between the amount of payment that was made to the provider and an estimate of payments that CMS would have made had the facility not been provider-based. It is conceivable that overpayments may have been made, not only for IME but also for direct GME, to a teaching hospital that incorrectly treated a facility as provider-based, and, as such, we would recover an amount of payment for both IME and direct GME that would otherwise not have been received by the hospital had the facility been freestanding.

(2) Good Faith Effort

We proposed to retain the existing exception for good faith effort (proposed redesignated § 413.65(j)(2)). Under this exception, we specified that we would not recover any payments for any period before the beginning of the hospital's first cost reporting period beginning on or after January 10, 2001 (the effective date of the existing provider-based regulations for providers not grandfathered under § 413.65(b)(2)) if during all of that period—

- The requirements regarding licensure and public awareness at § 413.65(d)(1) and proposed redesignated (d)(4) were met;
- All facility services were billed as if they had been furnished by a department of a provider, a remote location of a hospital, a satellite facility, or a provider-based entity of the main provider; and
- All professional services of physicians and other practitioners were billed with the correct site-of-service indicator, as described at § 413.65(g)(2).

Under § 413.65(j)(5), we proposed that CMS would continue payment to a provider for services of a facility or organization for a limited period of time, in order to allow the facility or organization or its practitioners to meet necessary enrollment and other requirements for billing on a freestanding basis. Specifically, the notice of denial of provider-based status sent to the provider would ask the provider to notify CMS in writing, within 30 days of the date the notice is issued, as to whether the provider intends to seek an advance determination of provider-based status for the facility or organization, or whether the facility or organization (or, where applicable, the practitioners who staff the facility or organization) will be seeking to enroll and meet other requirements to bill for services as a freestanding facility.

If the provider indicates that it will not be seeking an advance determination or that the facility or organization or its practitioners will not be seeking to enroll, or if CMS does not receive a response within 30 days of the date the notice was issued, all payments under proposed paragraph (j)(5) would end as of the 30th day after the date of notice. If the provider indicates that it will be seeking an advance determination, or that the facility or organization or its practitioners will be seeking to meet enrollment and other requirements for billing for services in a freestanding facility, payment for services of the facility or organization would continue, at the adjusted amount described in proposed paragraph (j)(4) for as long as is required for all billing requirements to be met (but not longer than 6 months).

Continued payment would be allowed only if the provider or the facility or organization or its practitioners submits, as applicable, a complete request for an advance provider-based determination or a complete enrollment application and provide all other required information within 90 days after the date of notice; and the facility or organization or its practitioners furnishes all other information needed by CMS to process the request for provider-based status or, as applicable, the enrollment application and verify that other billing requirements are met. If the necessary applications or information are not provided, CMS would terminate all payment to the

provider, facility, or organization as of the date CMS issues notice that necessary applications or information have not been submitted.

As clarified in § 413.65(o) of this final rule, we would not resume provider-based payment to such a facility or organization based on an attestation of compliance. On the contrary, if a facility or organization is found by CMS to have been inappropriately treated as provider-based under paragraph (j) for any period on or after October 1, 2002 (or, in the case of facilities or organizations described in § 413.65(b)(2), for cost reporting periods starting on or after July 1, 2003), CMS will not treat the facility or organization as provider-based for payment until CMS has determined, based on documentation submitted by the provider, that the facility or organization meets all requirements for provider-based status under Part 413.

Comment: One commenter suggested that, given the complexities surrounding the provider-based rules and the delays in implementing the regulations and establishing a uniform process, the final rule should provide that any provider that complies with the good faith exception under § 413.65(j)(2) should also not be subject to any retroactive recoupment of payments under proposed paragraphs (j) and (k).

Response: The regulations at § 413.65(j)(2) state that recovery of overpayments will not be made for any period before the beginning of the hospital's first cost reporting period beginning on or after January 10, 2001, if the provider made a good faith effort to treat its facilities as provider-based during all that period. This good faith exception was originally included in the April 7, 2000 regulations (originally applicable to periods before October 10, 2000, the original effective date of the provider-based regulations, but subsequently delayed to January 10, 2001).

We believe a good faith exception is appropriate for cost reporting periods beginning before January 10, 2001, when the provider-based regulations first became effective, since it would protect providers that were unaware of the new regulations, yet operated facilities that met a minimal threshold for integration. However, CMS has now published two proposed rules and one final rule on provider-based status, has published ''Qs and As'' on its website, and has consulted extensively with the hospital industry through teleconferences and meetings. Given the publicity that the provider-based regulations have received and the latest delayed effective date of these rules, we do not believe it is appropriate to extend the scope of the good faith exception.

Accordingly, we are adopting the proposals discussed above as final. In addition, we are revising section 413.65(j)(2)(ii) to refer to ''billed with the correct site-of-service'' rather than ''site-of-service indicator'', for consistency with the revision to § 413.65(g)(2) described above.

j. Temporary Treatment as Provider-Based and Correction of Errors

Under proposed revised § 413.65(k), we proposed to specify the procedures for payment for the period between the time a request is submitted until a provider-based determination is made, and the steps we would take if we discover that a facility for which a provider previously received a provider-based determination no longer meets the requirements for provider-based status.

First, we proposed that, if a provider submits a complete request for a provider-based determination for a facility that has not previously been found by CMS to have been inappropriately treated as provider-based under proposed revised § 413.65(j), the provider may bill and be paid for services at the facility as provider-based from the date of the application until the date that we determine that the facility or organization does not meet the provider-based rules under § 413.65. If CMS determines that the requirements for provider-based status are not met, CMS will recover the difference between the amount of payments that actually was made since the date the complete request for a provider-based determination was submitted and the amount of payments that CMS estimates should have been made in the absence of compliance with the provider-based requirements. We indicated that we would consider a request ''complete'' only if it included all information we need to make an advance determination of provider-based status under § 413.65(b)(3).

Second, similar to what we specify in existing § 413.65(k), if we determine that a facility or organization that previously received a provider-based determination no longer qualifies for provider-based status, and the failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that the provider reported to CMS under § 413.65(c), treatment of the facility or organization as provider-based ceases with the date that CMS determines that the facility or organization no longer qualifies for provider-based status.

Third, if we determine that a facility or organization that had previously received a provider-based determination no longer qualifies for provider-based status, and if the failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that the provider did not report to CMS, as required under § 413.65(c), we proposed to take the actions with respect to notice to the provider, adjustment of payments, and continuation of payment described in proposed paragraphs (j)(3), (j)(4), and (j)(5). In short, we would treat such cases in the same way as if the provider had never obtained an advance determination. However, with respect to recovery of past payments for providers included in the grandfathering provision at proposed revised § 413.65(b)(2), we proposed not to recover payments for any period before the provider's first cost reporting period beginning on or after July 1, 2003.

Also, we proposed that, as under regulations currently in effect, the exception for good faith concerning recovery of overpayments under proposed revised §§ 413.65(j)(2) described above would only apply to any period before the beginning of the hospital's first cost reporting period beginning on or after January 10, 2001.

Comment: One commenter requested that provider-based payment for services of a facility be allowed to continue while the facility is challenging any determination that it is not provider-based.

Response: As we explain in the proposed revised regulations at § 413.65(k), provider-based payment for services at a facility will continue until the date that CMS determines that the facility does not meet the provider-based rules. Once a determination concluding that a facility does not meet the provider-based rules is made, we believe it is inappropriate to continue paying for services at that facility as provider-based. Then, depending upon a number of factors, including whether the facility had previously been determined by CMS to be provider-based and whether the loss of provider-based status resulted from a material change that was or was not reported to CMS, CMS will take actions with respect to recovery of overpayments and continuation of payments at the appropriate nonprovider-based reduced rate, as described in the proposed revised § 413.65(j).

Comment: One commenter noted that proposed paragraph (k) contains some rules applicable to facilities for which there has not been a previous

determination of provider-based status (paragraph (k)(1)) and others that apply to facilities for which such a determination has been made (paragraphs (k)(2) and (k)(3)). The commenter believed these rules would be more clearly understood if the rules for each situation were stated in separate paragraphs.

Response: We agree with the commenter. In this final rule, we are placing the text of proposed paragraph (k)(1) concerning facilities for which there has been no previous determination in new paragraph (k), and the text of proposed paragraphs (k)(2) and (k)(3) concerning facilities for which previous determinations have been made in paragraph (l). Proposed sections (l) through (n) are being redesignated as paragraphs (m) through (o).

In addition, as noted earlier in this preamble, we state in § 413.85(o) of this final rule that, effective for any period on or after October 1, 2002 (or, in the case of facilities or organizations described in § 413.85(b)(2), for cost reporting periods starting on or after July l, 2003), if a facility or organization previously was determined by CMS to be provider-based but no longer qualifies as provider-based because of a material change occurring during those periods that was not reported to CMS, CMS will not treat the facility or organization as provider-based for payment until CMS has determined, based on documentation submitted by the provider, that the facility or organization meets all requirements for provider-based status under Part 413.

Comment: Regarding the references in paragraphs (k)(1) and (k)(2) of proposed § 413.65 (to be redesignated as (l)(2) and (l)(3), as explained above) to reporting of material changes in the relationship between a provider and a facility or organization that had been found to be provider based, one commenter recommended that the term ''material change'' be defined more specifically, to give providers more direction as to what events to report. The commenter believed a material change should be defined as including only ''a change of ownership, adoption of a new management contract for an off-campus department of a provider or a provider-based entity, change to an off-campus location, or a change in licensure status.''

Response: We share the commenter's belief that the events listed would be considered material changes. However, we do not agree that the term ''material change'' should include only these events. On the contrary, other types of occurrences, such as formation of a separate medical staff for the facility or organization or discontinuation of a service on the main provider's campus that would prevent referral of patients from the facility organization to the main provider would also represent material changes. Because we believe limiting the definition of the term ''material change'' as suggested by the commenter would inappropriately restrict the range of events to be reported, we are not adopting this comment.

Comment: One commenter recommended that reporting of material changes not be required for on-campus facilities. The commenter believed this reporting is unnecessary because adequate safeguards are already built into the provider enrollment requirements.

Response: Several of the kinds of changes noted in response to the preceding comment, relating to the integration of clinical services of the facility or organization with those of the main provider, are not subject to any mandatory reporting under the provider enrollment process but could affect provider-based status. Therefore, we are not making any change in the final rule based on this comment.

Comment: One commenter noted that, in the preamble to the proposed rule, CMS states that there would be '' * * * a delay in the effective date for any facility that is found not to meet the provider-based criteria following a previous advance determination, if the reason the provider-based criteria are not met is a material change in the provider-facility relationship that was properly reported to CMS. The removal of provider-based status would be effective following notification of the redetermination, but not less than 6 months after the date of notification'' (67 FR 31483). The commenter pointed out that this minimum 6-month compliance period is not included in the proposed § 413.65(k)(2). Rather, this regulation states that under these circumstances, provider-based status ''ceases with the date that CMS determines that the facility or organization no longer qualifies for provider-based status.'' The commenter requested that CMS revise § 413.65(k)(2) to reflect the minimum 6-month compliance period.

Response: We agree that the language quoted by the commenter from page 31483 of the preamble to the proposed rule is inconsistent with the language in the proposed regulations text. While this language is consistent with the current policy as stated in existing § 413.65(k), the inclusion of the language on page 31483 of the proposed rule was inadvertent on our part. We note that the correct proposed policy, which correctly *mirrors* the proposed regulation text at § 413.65(k)(2), is stated on page 31487 of the proposed rule. Specifically, we state that ''if we determine that a facility of organization that had previously received a provider-based determination no longer qualifies for provider-based status, and if the failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that the provider reported to CMS under § 413.65(c), treatment of the facility or organization as provider-based ceases with the date that CMS determines that the facility or organization no longer qualifies for provider-based status.'' We did not intend to propose to allow a 6-month grace period before a facility's status as provider-based would be revoked.

While we regret the confusion caused, we are not adopting the commenter's request regarding a 6-month grace period prior to removal of a provider-based status designation, since we do not believe it would be appropriate to provide for payment to the provider as provider-based for a period for which the provider was clearly not provider-based. While we do not plan to recover overpayments from a facility or organization that no longer qualifies as provider-based if the provider reported a material change in the relationship between the provider and the facility or organization, CMS retains the authority to recoup overpayments and apply civil monetary penalties if a provider is in violation of section 1128A or 1128B of the Act.

Accordingly, we are adopting our proposals as final with the following changes: We are reorganizing the text of proposed § 413.65(k) into new paragraphs (k) and (1), without substantive change, to distinguish the rules applicable to facilities for which there has been no previous determination from those that apply to facilities for which a previous determination has been made. Proposed sections (l) through (n) are being redesignated as paragraphs (m) through (o).

k. Technical Amendments

We proposed to correct a typographical error in the heading of paragraph (m) of § 413.65 (redesignated as paragraph (n) in this final rule) so that it reads ''FQHCs and ''look alikes' '.

In paragraph (n) of § 413.65 (redesignated as paragraph (o) in this final rule), we proposed to add a cross-reference to the requirements for

provider-based status described in paragraph (b), for purposes of specifying the effective date of provider-based status.

We did not receive any public comments on these technical amendments and are adopting them as final without change except for the redesignation of paragraph codes indicated above.

L. CMS Authority Over Reopening of Intermediary Determinations and Intermediary Hearing Decisions on Provider Reimbursement

Our existing regulations provide various means for the reopening and revision of an intermediary determination or an intermediary hearing decision on provider reimbursement by the fiscal intermediary or the intermediary hearing officer(s) responsible for the determination or the hearing decision, respectively. (In this discussion, we will use the term ''intermediary'' to refer to, as applicable, the intermediary responsible for an intermediary determination (see §§ 405.1801(a) and 405.1803) or the intermediary hearing officer or panel of intermediary hearing officers responsible for an intermediary hearing decision (see §§ 405.1817 and 405.1831.)) Section 405.1885(a) provides that an intermediary ''may'' reopen an intermediary determination or an intermediary hearing decision, on its own initiative or at the request of a provider, within 3 years of the date of the notice of the intermediary determination or intermediary hearing decision. However, while § 405.1885(a) provides the intermediary with some discretion about whether to reopen an intermediary determination or an intermediary hearing decision, we have always considered the intermediary's discretion to be limited by any directives that we may issue. Thus, although § 405.1885(a) provides that the intermediary ''may'' reopen, that provision neither states nor implies that the Secretary lacks authority to direct the intermediary to reopen or not reopen a specific matter. Furthermore, we have prescribed, in Medicare Provider Reimbursement Manual, Part I (''PRM''), section 2931.2, criteria that guide the intermediary's reopening actions under § 405.1885(a) in the absence of a particular CMS directive. Also, given that the intermediaries are our (CMS') contractors, we have always believed that, under basic principles of agency law, we have inherent authority to direct the actions of our own agents with respect to reopening matters under § 405.1885(a), just as for any other aspect of program administration. (See also 42 U.S.C. 1395h and 1395kk(a); and 42 CFR 421.1(c), 421.5(b), 421.100(f), 421.124(a), and 421.126(b).)

Under § 405.1885(b), an intermediary determination or an intermediary hearing decision ''must be reopened and revised by the intermediary if, within the aforementioned 3-year period, the Centers for Medicare & Medicaid Services notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations, or general instructions issued by the Centers for Medicare & Medicaid Services.'' We have always considered our notice, which is a precondition of mandatory intermediary reopening under § 405.1885(b), to be one in which we explicitly direct the intermediary to reopen. We have never considered a notice or other document from us that only states or implies that an intermediary determination or an intermediary hearing decision is inconsistent with law, regulations, CMS ruling, or CMS general instructions, sufficient to require intermediary reopening under § 405.1885(b). Moreover, our understanding has always been that the phrase ''law, regulations, or general instructions'' in § 405.1885(b) refers to the legal provisions in effect, as we understood such legal provisions at the time the intermediary rendered the determination or hearing decision. Conversely, we have never considered changes in, or judicial explications of, ''law, regulations, or general instructions,'' that occur after the intermediary rendered the determination or hearing decision, sufficient to require intermediary reopening under § 405.1885(b). Also, § 405.1885(b) refers to the Secretary's agreement with an intermediary; we believe such agreement requires the intermediary to apply the law, regulations, CMS rulings, and CMS general instructions in effect, as we understood such legal provisions when the intermediary determination or hearing decision was rendered. Accordingly, we have not instructed intermediaries to reopen and recover reimbursement, or to reopen and award additional reimbursement, due to a subsequent change in law or policy, whether the subsequent change is made in response to judicial precedent or otherwise.

Section 405.1885(c) provides: ''Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.'' We have always interpreted § 405.1885(c) to provide that authority to reopen an intermediary determination or an intermediary hearing decision is vested exclusively with the responsible intermediary, as distinct from the Provider Reimbursement Review Board (PRRB) and the CMS Administrator (in the context of reviewing PRRB decisions (see § 405.1875)) which may not reopen an intermediary determination or hearing decision and may not review an intermediary's denial of reopening. However, we have never considered the intermediary's authority to reopen an intermediary determination or hearing decision, which is exclusive under § 405.1885(c) only as to the PRRB and the CMS Administrator (in the context of reviewing PRRB decisions), to limit our authority to direct the actions of our agents with respect to reopening matters. (*See Your Home Visiting Nurse Services, Inc.* v. *Shalala,* 525 U.S. 449, 452–53 (1999)(§ 405.1885(c) divests the PRRB of ''appellate jurisdiction to review the intermediary's refusal'' to reopen, but does not limit the Secretary's authority to direct an intermediary's ''original jurisdiction'' in the reopening area).) As discussed previously, the regulations do not constrain our authority to direct the intermediary to reopen or not reopen a specific matter; instead, we have placed generally applicable limits on the intermediary's discretion through the reopening criteria prescribed in section 2931.2 of the PRM. In addition, we have always believed that, under basic principles of agency law, the intermediary's discretion over a particular reopening matter is no less circumscribed by any CMS directives that may be issued than would be the case for any other aspect of program administration.

Two recent court decisions conflict with our longstanding interpretation of the forgoing provisions of the reopening regulations. In *Monmouth Medical Center* v. *Thompson,* 257 F.3d 807 (D.C. Cir. 2001), the court found that a statement in a CMS ruling, changing CMS' interpretation of the statute in response to circuit court precedent, constituted a directive to the intermediary under § 405.1885(b) to reopen, notwithstanding an explicit directive in the CMS ruling that the change in interpretation was to be applied only prospectively. The court ordered the intermediary to reopen over the Secretary's objection. We disagree with the court's decision, which we believe does not comport with our settled interpretation (discussed above) of § 405.1885(b). Therefore, in the May 9, 2002 proposed rule, we proposed to revise § 405.1885(b) to make clear that,

in order to trigger the intermediary's obligation to reopen, our notice to the intermediary must explicitly direct the intermediary to reopen based on a finding that an intermediary determination or an intermediary hearing decision is inconsistent with the law, regulations, CMS ruling, or CMS general instructions in effect, and as we understood those legal provisions, at the time the determination or decision was rendered. We also proposed to clarify § 405.1885 to reflect our longstanding interpretation (discussed above) that a change of legal interpretation or policy through regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening an intermediary determination or an intermediary hearing decision under this section.

The *Monmouth Medical Center* decision was followed in *Bartlett Memorial Medical Center* v. *Thompson,* 171 F. Supp. 2d 1215 (W.D. Okla. 2001). In a subsequent order in the *Bartlett Memorial Medical Center* case, the court concluded that a CMS ruling, which prohibited intermediary reopening on a particular reimbursement issue, improperly interfered with the intermediary's discretion under § 405.1885(c) over provider requests for reopening under § 405.1885(a). Accordingly, the court ordered the intermediary to act on the provider reopening requests without regard to the CMS ruling or any other involvement of the Secretary. We disagree with the court's decision, which we believe is contrary to our settled interpretation (discussed above) of §§ 405.1885(a) and (c). We believe the court's decision is also inconsistent with our inherent authority to direct the activities of our contractor-agents, the fiscal intermediaries, with respect to particular reopening matters, just as with any other aspect of program administration. Therefore, we proposed, in a new paragraph (e) of § 405.1885 (the existing paragraph was proposed to be redesignated as paragraph (f)), to clarify that, notwithstanding an intermediary's discretion to reopen or not reopen under paragraphs (a) and (c) of § 405.1885, we may direct an intermediary to reopen, or not to reopen, an intermediary determination or an intermediary hearing decision in accordance with paragraphs (a) and (c) of this section.

We received a number of comments regarding the proposed revisions to the reopening rules. The commenters largely opposed the our proposed revisions to § 405.1885. Their comments and our responses are as follows.

Comment: A fiscal intermediary asked if CMS was implicitly proposing to make all reopening decisions. According to another commenter, the proposed rule would enhance CMS' control over the reopening process by displacing the intermediary's role as the evaluator of the merits of reopening matters.

Response: The revisions to the reopening regulations are not intended to change the usual allocation of responsibilities between CMS and the fiscal intermediaries, which leaves most reopening decisions to the intermediaries. We are simply clarifying the regulations to reflect our longstanding interpretations, not revamping settled reopening policies and procedures.

As the courts have recognized, the reopening regulations are based on the Secretary's general rulemaking authority. (See *HCA Health Servs. of Oklahoma, Inc.* v. *Shalala,* 27 F.3d 614, 618 (D.C. Cir. 1994).) In the past, our main role has been to provide general guidance regarding the reopening regulations, such as the instructions included in Chapter 29 of the Medicare Provider Reimbursement Manual, Part 1 (''PRM''). The intermediaries have typically decided, without consulting with us, whether to reopen specific intermediary determinations or hearing decisions in accordance with §§ 405.1885(a) and (c) and the PRM. Of course, our authority to require intermediary reopening has been recognized specifically in § 405.1885(b). In certain instances, we have directed the intermediaries' reopening actions on a recurring reimbursement issue, such as the ''disproportionate share'' issue addressed in HCFA Ruling 97–2 (February 27, 1997). On occasion, we have instructed an intermediary to reopen a specific matter, such as in implementing the settlement of an administrative appeal or a lawsuit.

The foregoing allocation of responsibilities is not altered by the revisions to the reopening regulations. Rather, we are clarifying the regulations to comport with our longstanding interpretation that the intermediary's duty to reopen a determination or decision under § 405.1885(b) arises only if we specifically direct it to reopen in order to ensure consistency with a legal provision, as we understood such provision when the determination or decision was issued. Moreover, revised § 405.1885(e) simply clarifies our interpretation that the intermediary's discretion whether to reopen under §§ 405.1885(a) and (c) is subject to CMS' authority to direct the ''original jurisdiction'' of its own contractor over reopening matters, as with any other area of program administration. Thus, while the intermediaries will continue to decide most reopening matters without consulting with CMS, § 405.1885(e) reflects our authority to direct the intermediaries as we deem necessary and appropriate.

Comment: Two commenters stated that the reopening process has been the province of the intermediary. According to the commenters, the proposed changes to § 405.1885(e) would give CMS the sole authority to decide reopening matters that were formerly the intermediary's responsibility, which would eliminate the discretionary character of intermediary reopening decisions. Thus, the commenters concluded, intermediary reopening denials would be subject to PRRB and judicial review despite the Supreme Court's decision in *Your Home Visiting Nurse Services, Inc.* v. *Shalala,* 525 U.S. 449 (1999).

Response: We disagree with the commenters' assertion that the proposed revisions to the reopening regulations would affect the reviewability of intermediary reopening denials. As discussed above, although the intermediaries have typically decided, without consulting with CMS, whether to reopen specific intermediary determinations or hearing decisions, the contractors' reopening actions have always been subject to the general guidance and any particular directives issued by CMS. Again, the respective roles of CMS and the intermediaries are simply not changed by the revisions to the reopening regulations. Since the intermediaries will continue to decide most reopening matters without consulting with CMS, reopening decisions will typically reflect the usual exercise of the intermediary's unreviewable discretion.

Although the revisions to the reopening regulations pertain to different issues than those resolved by the Supreme Court's *Your Home Visiting Nurse* decision, we believe that the revised regulations are consistent with the Court's decision and related precedent. The Supreme Court held that an intermediary's rejection of a provider's reopening request is not reviewable by the PRRB or the Federal courts. *Your Home Visiting Nurse Services, Inc.* v. *Shalala,* 525 U.S. at 452–58. The revisions to the reopening regulations do not address or affect the reviewability of intermediary reopening denials. Rather, the revisions clarify our settled policies regarding the intermediary's original jurisdiction over the reopening question. *Id.* at 453. Specifically, the revisions to

§ 405.1885(b) clarify our longstanding view that intermediary reopening is required only if we specifically mandate reopening in order to ensure consistency with a legal provision, as we understood such provision when the intermediary determination or decision was issued. Furthermore, as proposed, revised § 405.1885(e) clarifies our understanding that the intermediary's discretion whether to reopen under §§ 405.1885(a) and (c) is subject to our authority to direct the original jurisdiction of our contractor over reopening matters, as with any other area of program administration.

We recognize that the Supreme Court, in rejecting mandamus relief in *Your Home Visiting Nurse* for lack of a ''clear nondiscretionary duty,'' reasoned that § 405.1885(a) and PRM section 2931.2 permit but do not require reopening. *Your Home Visiting Nurse Services, Inc.* v. *Shalala,* 525 U.S. at 456–57. (However, we note that intermediary discretion did not figure in the Court's rejection of PRRB and Federal question jurisdiction over intermediary reopening denials. *Id.* at 452–56.) Given that the intermediaries will decide most reopening matters without consulting us, as in the past, such decisions will still be based on the discretionary provisions of § 405.1885(a) and PRM section 2931.2 and thus *Your Home Visiting Nurse* will be squarely on point.

We believe that a reopening denial is no less discretionary—and unreviewable under Your *Home Visiting Nurse* and related precedent—when we mandate the intermediary's action. Notably, in both *Monmouth Medical Center* and *Bartlett Memorial Medical Center,* the courts rejected PRRB and federal question jurisdiction over the prohibition of intermediary reopening included in HCFA Ruling 97–2. *Monmouth Medical Center* v. *Thompson,* 257 F.3d at 810–13; *Bartlett Memorial Medical Center.* v. *Thompson,* 171 F. Supp. 2d at 1220–22. Mandamus relief was ordered in both cases, based on the courts' finding that the Ruling engendered a clear nondiscretionary duty to reopen under § 405.1885(b). However, the Supreme Court has consistently held that reopening denials are ''committed to agency discretion by law' within the meaning of the Administrative Procedure Act, and hence unreviewable.'' *Your Home Visiting Nurse Services, Inc.* v. *Shalala,* 525 U.S. at 457 (following *ICC* v. *Locomotive Engineers,* 482 U.S. 270, 282 (1987)). We believe that, under basic principles of agency law, it would be incongruous to suppose that reopening denials required by the principal, CMS, are somehow less discretionary than denials based on the judgment of our agents, the fiscal intermediaries. (See *ICC* v. *Locomotive Engineers,* 482 U.S. at 277B84 (despite statutory authorization of reopening for material error, Interstate Commerce Commission's refusal to reopen is committed to the agency's unreviewable discretion by law).)

Comment: A commenter stated that CMS should not restrict intermediaries' ability to reopen cost reports when they find it fair and appropriate to do so. The commenter explained that, in dealing with thousands of providers throughout the country, the intermediaries encounter numerous factual scenarios that different contractors might treat through varying means. The commenter concluded that, if a statute or regulation is ambiguous and CMS has not issued a policy statement on an issue, the intermediaries should be free to decide whether to reopen the matter and make revisions deemed suitable.

Response: In the absence of a CMS directive, intermediary reopening decisions have been guided by the criteria of ''new and material evidence,'' ''clear and obvious error,'' and consistency with a legal provision. (See PRM section 2931.2.) The revisions to the reopening regulations do not change the PRM guidelines. Instead, revised § 405.1885(e) clarifies our settled view that we have full authority to direct an intermediary to reopen, or not to reopen, under §§ 405.1885(a) and (c) based on the PRM reopening criteria.

However, as explained above, the intermediaries will continue to decide most reopening matters without consulting with CMS. In cases where we have not interpreted a statute or regulation or issued a policy statement on a reimbursement issue, the intermediaries will typically be free to decide whether to reopen the matter. Although the different intermediaries will be guided by the reopening guidelines in the PRM, different contractors may reach varying decisions on whether to reopen, or how to revise, a determination or decision. The traditional flexibility and variability of intermediary reopening decisions will not change as a result of the revisions to the reopening regulations.

Comment: A commenter stated that if CMS publishes a policy statement clarifying a particular Medicare issue, the intermediaries should have the ability to reopen cost reports to ensure that all providers are treated uniformly. Another commenter stated that it is not reasonable to expect intermediaries to apply rulings retroactively in some instances.

Response: We believe that an important component of a new reimbursement policy is the policy's scope of applicability. Given that Medicare is a uniform nationwide program, we typically do not leave to the discretion of the intermediaries questions about the scope of applicability of our reimbursement policy or policy clarification. Instead, a CMS regulation or policy guideline on a reimbursement issue usually includes an effective date. New reimbursement policies normally apply on a prospective-only basis. (See *Bowen* v. *Georgetown University Hospital,* 488 U.S. 204, 208–16 (1988) (Medicare statute does not permit retroactive rulemaking).) The alternative suggested by the commenter, of letting the intermediaries determine through reopening the scope of applicability of a new CMS reimbursement policy, would undermine the interests of nationally uniform program administration. Also, if the intermediaries were to reopen and apply a reimbursement policy that was not in place when payment was determined originally, such reopenings might involve impermissible retroactive rulemaking.

Comment: A commenter asserted that the proposed revisions to § 405.1885(b) would inappropriately expand CMS' authority by permitting the agency to order an intermediary to disregard a judicial decision holding a policy void *ab initio,* on the theory that CMS understood the disputed legal provision differently when the intermediary determination was rendered. Thus, the commenter concluded, the proposal violates fundamental principles of separation of powers.

Response: The revisions to § 405.1885(b) do not expand our reopening authority. Rather, revised paragraph (b)(1) clarifies our settled interpretation that an intermediary's duty to reopen a determination or decision under § 405.1885(b) arises only if we specifically direct it to reopen in order to ensure consistency with a legal provision, as we understood such provision when the determination or decision was issued.

We did not propose paragraph (b)(1) as a means of sidestepping a judicial decision holding a reimbursement policy void *ab initio,* on the theory that we understood the disputed legal provision differently when the intermediary determination at issue in the lawsuit was rendered. If a provider secures a final, nonappealable judgment rejecting a reimbursement policy, we would certainly comply with such a court judgment for the provider's fiscal

period at issue in the lawsuit— even if we had a different understanding of the law when the intermediary determination at issue in the case was rendered. Given our compliance with the final, nonappealable judicial decision, there clearly would be no separation of powers problem.

The commenter may be assuming that reopening is necessary for the implementation of a final, nonappealable judgment. That would be a debatable assumption for a number of reasons. For example, we would be required to redetermine reimbursement in accordance with a final, nonappealable court judgment for the fiscal period at issue in the lawsuit, even if the 3-year period for reopening the intermediary determination at issue in the case had expired long ago. Also, we often implement final adverse judgments and lawsuit settlement agreements outside the reopening process. Instead of reopening the reimbursement matter and issuing a revised notice of program reimbursement (see §§ 405.1801(a), 405.1803, and 405.1889), we may simply recalculate reimbursement in accordance with the final court decision or settlement agreement, and issue an implementation notice detailing the reimbursement effect of the court judgment or settlement agreement.

However, the comment does indicate that the proposed rule was susceptible to the interpretation that CMS would be precluded from requiring the reopening of a particular intermediary determination or decision in order to implement a specific final agency decision (see §§ 405.1833, 405.1871(b), 405.1875, and 405.1877(a)); a particular final, nonappealable court judgment; or a specific agreement to settle an administrative appeal or a lawsuit. In order to allay the commenter's concern and make explicit our authority to use reopening procedures in such circumstances, as we deem appropriate, we have added a new paragraph (b)(3) to proposed § 405.1885(b). Paragraph (b)(3) states that notwithstanding paragraph (b)(1)(i) of this section, CMS may direct the intermediary to reopen a particular intermediary determination or intermediary hearing decision in order to implement, for the same intermediary determination or intermediary decision— (1) a final agency decision under §§ 405.1833, 405.1871(b), 405.1875, or 405.1877(a); (2) a final nonappealable court judgment; or (3) an agreement to settle an administrative appeal or a lawsuit.

Comment: According to one commenter, the inclusion of the condition ''as CMS understood those legal provisions, at the time the [intermediary] determination or decision was rendered,'' in the provisions of § 405.1885(b) for mandatory intermediary reopening would give CMS unlimited and standardless discretion whether or not to reopen.

Response: Paragraph (b)(1)(i) does include a guideline for CMS' decision whether to require intermediary reopening under § 405.1885(b). If an intermediary determination or decision is inconsistent with the applicable law, regulations, CMS Ruling, or CMS general instructions in effect, as CMS understood such legal provisions when the intermediary rendered the determination or decision, then CMS may decide to direct the intermediary to reopen and revise the determination or decision. However, we are not required to mandate intermediary reopening in such cases. Thus, given the Supreme Court's decisions in *Your Home Visiting Nurse* and *ICC* v. *Locomotive Engineers,* if CMS directs the intermediary to not reopen, our instruction and the intermediary reopening denial are committed to the agency s unreviewable discretion under the Administrative Procedure Act, 5 U.S.C. 701(a)(2).

Moreover, we believe that our longstanding practice of looking to the law in effect, as we understood the law, when the intermediary determination or decision was rendered, is supported by analogous principles followed by the courts. For example, it is settled that '' 'the legal effect of conduct should ordinarily be assessed under the law that existed when the conduct took place.' '' *Landgraf* v. *USI Film Products,* 511 U.S. 244, 265 (1994) (citation omitted). Also, the courts consistently hold that past judicial decisions, even if subsequently deemed erroneous, are *res judicata* and should not be resurrected and redecided. (See, *Federated Department Stores, Inc.* v. *Moitie,* 452 U.S. 394, 398 (1981).) Of course, this principle works both ways: if a disposition benefiting a claimant becomes final before a contrary decision on the same issue in another case, the claimant is not required to surrender the benefit despite the intervening change in decisional law. (See, *Aaron* v. *Kansas,* 115 F.3d 813, 814 n.1 (10th Cir. 1997).)

Comment: One commenter asserted that when the courts find a CMS policy unlawful, and the agency revises its policy to comport with the courts' decisions, providers should be entitled to reopening and application of the new policy within applicable time limits. According to a hospital system, foreclosing reopening of a matter that was settled inconsistently with decisional law would lead to inconsistent decisions regarding different providers, and have the agency persist in conduct held unlawful by the courts.

Response: We disagree. As proposed, paragraph (b)(2) clarifies our longstanding view that a change of legal interpretation or policy by CMS, whether made in response to judicial precedent or otherwise, is not a basis for reopening an intermediary determination or decision under § 405.1885.

The prospect of widespread reopening for application of a new legal interpretation or policy, whether in response to judicial precedent or otherwise, might involve impermissible retroactive rulemaking. (See *Bowen* v. *Georgetown University Hospital,* 488 U.S. at 208–16.) If we were to allow systemic reopening for application of a legal interpretation or policy adopted in response to judicial precedent, our fiduciary responsibilities for the Medicare trust funds would arguably call for similarly widespread reopening when a new legal interpretation or policy is not favored by providers. The result might be a spate of litigation involving alleged retroactive rulemaking and other complex legal issues.

Furthermore, we have not viewed the reopening process as a ready alternative to the mechanism for administrative appeals and judicial review established by the Medicare statute and regulations. Under the statute (section 1878(a) of the Act) and the regulations (§§ 405.1801(a), 405.1803, and 405.1807), an ''intermediary determination'' is, by definition, a ''final determination'' of program reimbursement. We believe that, if a provider does not file a timely appeal of a final determination on a reimbursement issue, there is no right to reopening of that issue in light of judicial decisions in other cases on the same issue. Put simply, reopening is not designed for the revival of stale claims, *Albert Einstein Medical Center.* v. *Sullivan,* 830 F. Supp. 846, 850 (E.D. Pa. 1992), aff'd, 6 F.3d 778 (3d Cir. 1993), or the addition of new claims. *Saint Mary of Nazareth Hospital Center.* v. *Schweiker,* 741 F.2d 1447, 1449 (D.C. Cir. 1984).

In addition, we believe that our longstanding policy of not reopening for application of a new legal interpretation or policy, whether in response to judicial precedent or otherwise, comports with analogous judicial practice. When the Supreme Court decides a legal issue, the Court's ''controlling interpretation of federal law'' applies to ''all cases still open on

direct review,'' *Harper* v. *Virginia Department of Taxation,* 509 U.S. 86, 97 (1993), but ''[n]ew legal principles * * * do not apply to cases already closed.'' *Reynoldsville Casket Co.* v. *Hyde,* 514 U.S. 749, 758 (1995). Thus, while a provider that files a timely appeal may, if it ultimately prevails, be reimbursed differently for an item than providers that do not appeal timely, we do not believe that the decision in the prevailing provider's case should apply to other providers' cost reports that were closed and not appealed timely.

Our settled reopening policy, clarified in § 405.1885(b)(2), also furthers the interests of administrative finality in a program of extraordinary magnitude. For example, there were only 37 fiscal intermediaries in 1997 as compared to approximately 38,000 participating providers. Of course, each provider submits an annual cost report containing thousands of cost items, any one of which may give rise to a reimbursement issue. (See *Athens City Hospital, Inc.* v. *Schweiker,* 743 F.2d 1, 3 (D.C. Cir. 1984) (detailing cost report contents).) We believe it would be unworkable to reopen thousands of final, unappealed cost reports each time a judicial decision calls into question one of our many reimbursement policies. Indeed, the Supreme Court concluded that, ''given the administrative realities we would not be shocked by a system in which underpayments could never be the basis for reopening'' since the ''few dozen fiscal intermediaries often need three years * * * to discover overpayments in the tens of thousands of NPRs that they issue, while each * * * sophisticated Medicare-provider * * * is generally capable of identifying an underpayment in its own NPR within the 180-day time period specified in 42 U.S.C. 139500(a)(3)'' for an appeal to the PRRB. *Your Home Visiting Nurse Services, Inc.* v. *Shalala,* 525 U.S. at 455–56. Thus, instead of the ''persistent'' unlawful conduct suggested by the commenter, we believe that our policy of not reopening closed cost reports in response to decisions in other cases is essential for maintaining administrative finality in a program of extraordinary magnitude that is administered with limited resources.

Comment: A group of health law attorneys recommended that CMS propose more elaborate revisions to the reopening regulations. The commenter saw the need for an orderly process for the correction of factual errors and erroneous interpretations of Medicare law. Also, the commenter recommended that § 405.1885(b) be amended so that CMS must require intermediary reopening for all providers located in the jurisdiction of a court that declares a Medicare policy unlawful. The commenter stated that, in light of the Supreme Court's *Your Home Visiting Nurse* decision, § 405.1885(a) should be revised to require intermediaries to grant provider requests for reopening to correct factual errors and improper application of policy rather than leaving the reopening decision to the intermediaries' discretion. According to the same commenter, the regulations should also detail the circumstances, if any, in which the intermediary may reopen in light of a judicial decision or other change in law. In the same vein, a different commenter stated that some level of materiality should be established so that providers are not confronted with several sets of adjustments for various cost reporting years.

Response: We proposed revisions to the reopening regulations in response to the *Monmouth Medical Center* and *Bartlett Memorial Medical Center* decisions. Our limited purpose was to clarify longstanding interpretations of the reopening regulations, which we believe were misapprehended by the courts.

More elaborate revisions to the reopening regulations are beyond the scope of the proposed rule. In any event, we believe the reopening regulations and related provisions of the PRM provide an orderly process for the correction of factual errors and erroneous interpretations of the law in effect, as we understood the law, when the intermediary determination or decision was rendered. We also believe that the reopening criteria prescribed in PRM section 2931.2 provide the intermediaries with sufficient guidance regarding the materiality of a potential reopening and revision to program reimbursement.

In lieu of the commenter's suggestion that we allow reopening for application of a judicial decision in another case or for some other change in law, we have revised § 405.1885(b) to reflect our longstanding practice of not reopening for application of a new legal interpretation or policy, whether in response to judicial precedent or otherwise. As explained above, we believe this reopening policy avoids retroactive rulemaking problems; comports with analogous judicial practice and the limited nature of the reopening process; and furthers the goals of administrative finality in a program of extraordinary magnitude that is administered with limited resources.

We also do not believe that the Supreme Court's *Your Home Visiting Nurse* decision requires any revision to § 405.1885(a) or any other reopening provision. As discussed above, the Court's rejection of PRRB and Federal court review of intermediary reopening denials continues the ''tradition of nonreviewability * * * [of] refusals to reconsider * * * by agencies as by lower courts; * * * another tradition that [the Administrative Procedure Act,] 5 U.S.C. 701(a)(2) was meant to preserve.'' *ICC* v. *Locomotive Engineers,* 482 U.S. at 282. Thus, we believe *Your Home Visiting Nurse* and related precedent apply equally to intermediary reopening denials directed by CMS and to denials by the intermediary acting alone.

For the reasons discussed above and although the commenters largely opposed our proposed revisions to the reopening provisions, we are finalizing these provisions as proposed with a technical change to § 405.1885(b)(3).

VI. Changes to the Prospective Payment System for Capital-Related Costs

A. Background

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''in accordance with a prospective payment system established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the capital prospective payment system. We initially implemented the capital prospective payment system in the August 30, 1991 final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

Federal fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the prospective payment system for hospital inpatient capital-related costs. Beginning in FY 2002, capital prospective payment system payments were based solely on the Federal rate for the vast majority of hospitals. The basic methodology for determining capital prospective payments based on the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG Weight) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA Adjustment for hospitals located in

Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable)

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year that are specified in § 412.312(c) of existing regulations. (Refer to the August 1, 2001 final rule (66 FR 39910) for a summary of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals both during and after the transition period, and the policy for providing special exceptions.)

B. New Hospitals

Under the prospective payment system for capital-related costs, at § 412.300(b), a new hospital is defined as a hospital that is newly participating in the Medicare program (under current or previous ownership) for less than 2 years (see 56 FR 43418, August 30, 1991). During the 10-year transition period, under § 412.324(b), a new hospital was exempt from the capital prospective payment system for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Effective with its third cost reporting period, a new hospital was paid under the appropriate transition methodology (either hold-harmless or fully prospective) for the remainder of the transition period. (If the hold-harmless methodology were applicable, hold-harmless payments would be made for 8 years, even if they extend beyond the 10-year transition period, which ended beginning with cost reporting periods beginning during FY 2002.)

This payment provision was implemented to provide special protection to new hospitals during the transition period in response to concerns that prospective payments under a DRG system may not be adequate initially to cover the capital costs of newly built hospitals. These hospitals may not have sufficient occupancy in those initial 2 years and may have incurred significant capital startup costs, so that capital prospective payment system payments may not be sufficient. For instance, hospitals newly participating in the Medicare program may not initially have adequate Medicare utilization. Because capital prospective payment system payments are made on a per discharge basis, a hospital only receives payments for its capital-related costs upon discharge of its Medicare patients. In addition, these hospitals did not have an opportunity to reserve previous years' capital prospective payment system payments to finance capital projects.

While the regulations provided for payments based on a percentage of costs for new hospitals for the first 2 years during the 10-year transition period, no provision was made for new hospitals once the 10-year transition was completed. However, we believe that the rationale for the policy applies equally to new hospitals even after the completion of the 10-year transition period. Accordingly, in the May 9, 2002 proposed rule (67 FR 31488), we proposed, under § 412.304(c)(2), to provide special payment to new hospitals for cost reporting periods beginning on or after October 1, 2002. That is, we proposed to pay new hospitals, as defined under § 412.300(b), 85 percent of their reasonable costs for their first 2 years of operation. Effective with their third year of operation, a new hospital would be paid based on the Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital prospective payment system). We stated that we believe this amendment will provide for more appropriate payments to new hospitals for their capital-related costs since initial capital expenditures may reasonably exceed the capital prospective payment system per discharge payment based on the Federal rate. The capital prospective payment Federal rate is based on industry-wide average capital costs rather than the experience of a new hospital. We believe this policy will allow new hospitals to provide efficiency in the delivery of services and still make reasonable payments for their capital expenditures.

As was the case during the 10-year transition period, the new hospital exemption will only be available to those hospitals that have not received reasonable cost-based payments under the Medicare program in the past, and would need special protection during their initial period of operation. This exemption from the capital prospective payment system for the first 2 years of operation will not apply to a hospital that is ''new'' as an acute care hospital but that has operated in the past (under current or previous ownership) and has an historical Medicare asset base. Furthermore, a hospital that replaces its entire facility (regardless of a change of ownership) will not qualify for the new hospital exemption even though it may experience a significant change in its asset base. Thus, in accordance with § 412.300(b), a new hospital exemption will not apply in the following situations:

- A hospital that builds new or replacement facilities at the same or a new location, even if a change of ownership or a new leasing arrangement is involved;
- A hospital that closes and then reopens under the same or different ownership;
- A hospital that has been in operation for more than 2 years but has been participating in the Medicare program for less than 2 years; or
- A hospital that changes status from a prospective payment system-excluded hospital (paid under the TEFRA methodology) or another hospital prospective payment system (such as the inpatient rehabilitation facility prospective payment system) to a hospital that is subject to the capital prospective payment system for acute care hospitals.

Comment: Three commenters addressed our proposed policy for new hospitals after the 10-year transition period for cost reporting periods beginning on or after October 1, 2002. One commenter asked whether new providers would have the option of electing payment at 100 percent of the Federal rate for their first 2 years of operation rather than the special payment provision of 85 percent of their reasonable costs. Another commenter expressed concern about the negative impact the proposed policy would have on its facility if the policy were applied retroactively, while still another commenter requested that the policy be effective for new hospitals with cost reporting periods beginning on or after October 1, 2001 rather than October 1, 2002.

Response: We agree with the commenter's suggestion that new hospitals (as defined in § 412.300(b)) should have the option of electing payment for their first 2 years of operation through either the special payment provision for new hospitals at 85 percent of their reasonable costs, or beginning immediately to receive payments based on 100 percent of the Federal rate. However, the payment method that the new hospital selects would remain in effect through the hospital's first 2 years of operation; the hospital would not be allowed to revert to the alternate payment method. If 100 percent of the Federal rate is the payment method selected, the new hospital must make the request to the fiscal intermediary in writing by the later of December 1, 2002, or within 60 days of the start of the provider's cost reporting period. We are revising the regulations at § 412.304(c)(2) to reflect this change.

While we are making this change effective for cost reporting periods beginning on or after October 1, 2002, we are not making this change effective for any periods prior to that date because doing so would constitute retroactive rulemaking.

Accordingly, in this final rule, we are adopting as final the proposed regulation change at § 412.304(c), with modifications. In § 412.304(c)(2)(i), we are specifying that a new hospital is paid (1) 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost report ending at least 2 years after the hospital accepts its first patient; or (2) if the new hospital elects, 100 percent of the Federal rate under the capital prospective payment system. If the new hospital elects to be paid 100 percent of the Federal rate, it must make the request to the fiscal intermediary in writing by the later of December 1, 2002, or within 60 days of the start of the provider's cost reporting period. We are specifying that once a new hospital elects to be paid based on 100 percent of the Federal capital prospective payment rate, it may not revert to payment at 85 percent of its allowable Medicare inpatient hospital capital-related costs.

C. Extraordinary Circumstances

When we implemented the capital prospective payment system in FY 1992, a number of commenters requested that we provide for a separate exceptions payment to account for extraordinary circumstances beyond a hospital's control that would require the hospital to make unanticipated major capital expenditures (56 FR 43411, August 30, 1991). In response to the commenters' request, we provided in the regulations at § 412.348(f) that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a flood, a fire, or an earthquake. For more detailed information regarding this policy, refer to the August 30, 1991 **Federal Register** (56 FR 43411).

To clarify that this policy regarding additional payments for extraordinary circumstances also applies to periods beginning on or after October 1, 2001, in the May 9, 2002 proposed rule (67 FR 31489), we proposed to revise § 412.312 by adding a new paragraph (e) to specify that payment is made for extraordinary circumstances as provided for in § 412.348(f) for cost reporting periods after the transition period, that is, beginning on or after October 1, 2001.

We did not receive any comments on this proposal. Accordingly, we are adopting as final the proposed new § 412.312(e).

D. Restoration of the 2.1 Percent Reduction to the Standard Federal Capital Prospective Payment System Payment Rate

Section 1886(g)(1)(A) of the Act, as amended by section 4402 of Public Law 105–33, requires the Secretary to reduce the unadjusted standard Federal capital prospective payment system payment rate (and the unadjusted hospital-specific rate) by 2.1 percent for discharges on or after October 1, 1997, and through September 30, 2002, in addition to applying the budget neutrality factor used to determine the Federal capital prospective payment system payment rate in effect on September 30, 1995. The budget neutrality factor effective for September 30, 1995, was 0.8432 (59 FR 45416). Therefore, application of the budget neutrality factor (as specified under section 1886(g)(1)(A) of the Act) was equivalent to a 15.68 percent reduction to the unadjusted standard Federal capital prospective payment system payment rate and the unadjusted hospital-specific rate in effect on September 30, 1997. The additional 2.1 reduction to the rates in effect on September 30, 1997 resulted in a total reduction of 17.78 percent.

Accordingly, under the statute, the additional 2.1 percent reduction no longer applies to discharges occurring after September 30, 2002 (§ 412.308(b)(5)). Therefore, in the May 9, 2002 proposed rule (67 FR 31489), we proposed to revise § 412.308(b) to add a new paragraph (b)(6) to restore the 2.1 percent reduction to the unadjusted standard Federal capital prospective payment system payment rate (as provided under § 412.308(c)) for discharges occurring on or after October 1, 2002, to the level that it would have been without the reduction. (Since FY 2001 was the final year of the 10-year transition period, we no longer update the hospital-specific rate and, therefore, we also no longer restore the 2.1 percent reduction to that rate as provided under § 412.328(e)(1).)

As described in the August 29, 1997 final rule (62 FR 46012), we determined the reduction factor for FY 1998 by deducting both the FY 1995 budget neutrality factor (0.1568) and the 2.1 percent reduction (0.021) from 1 (1 − 0.1568 − 0.021 = 0.8222). We then applied the 0.8222 to the unadjusted standard Federal rate. Therefore, to determine the adjustment factor needed to restore the 2.1 percent reduction, we would divide the amount of the adjustment without the 2.1 percent reduction (1 − 0.1568 = 0.8432) by the amount of the adjustment with the 2.1 percent reduction (0.8222). Accordingly, we proposed to restore the 2.1 percent reduction for discharges occurring on or after October 1, 2002, under proposed § 412.308(b)(6), by applying a factor of 1.02554 (0.8432/0.8222) to the unadjusted standard Federal capital prospective payment system payment rate under § 412.308(c), that was in effect on September 30, 2002.

We did not receive any comments on this proposal and are, therefore, adopting as final the proposed new § 412.308(b)(6).

E. Clarification of Special Exceptions Policy

Under the special exceptions provisions at § 412.348(g), an additional payment may be made through the 10th year beyond the end of the capital prospective payment system transition period for eligible hospitals that meet (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). In accordance with § 412.348(g)(7), hospitals are eligible to receive special exceptions payments for the 10 years after the cost reporting year in which they complete their project, which can be no later than the hospital's cost reporting period beginning before October 1, 2001.

During the 10-year capital prospective payment system transition period, regular exceptions under §§ 412.348(b) through (e) are paid the same as or more (between 70 percent and 90 percent of costs, depending on the type of hospital) than the special exceptions provision under § 412.348(g) (70 percent for all eligible hospitals). Therefore, it was not until cost reporting periods beginning on or after October 1, 2001 (the end of the transition period) that eligible hospitals could actually begin receiving additional payments under the special exceptions provision. As we stated in the July 30, 1999 final rule (64 FR 41528), we believe that, since any substantive changes to this policy could have a significant impact, the appropriate forum for addressing the special exceptions policy is through the legislative process in Congress rather than the regulations process. Since hospitals are beginning to receive additional payments under this provision, we have received several

questions regarding the current policy at § 412.348(g). Therefore, in the May 9, 2002 proposed rule (67 FR 31490), we did not propose any changes to the special exceptions policy. However, we did provide the following clarifications to the existing regulations.

Under § 412.348(g)(1), to be eligible for special exception payments, a hospital must be either a sole community hospital (SCH), an urban hospital with at least 100 beds that has a disproportionate share (DSH) percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), or a hospital with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Because a hospital's SCH status, DSH patient percentage, and combined utilization may fluctuate from one cost reporting year to the next, the special exceptions eligibility criteria are applied for each cost reporting period throughout the 10-year special exceptions period. A hospital receives special exceptions payments only for those years in the 10-year period in which it meets the eligibility requirements in § 412.348(g)(1). Therefore, a hospital might be eligible for a special exception payment in one year, not be eligible the next year, and then subsequently qualify during the 10-year special exceptions period.

The project need criteria in § 412.348(g)(2) also state that a hospital must obtain any required approval from a State or local planning authority. However, in States where a certificate of need or approval is not required by the State or local planning authority, the hospital must provide the fiscal intermediary with appropriate documentation (such as project plans from the hospital's board of directors) that demonstrates that the requirements of § 412.348(g)(3) concerning the age of assets test and § 412.348(g)(4) concerning the excess capacity test for urban hospitals are met. We understand that a State planning authority and a hospital may define a project differently. Accordingly, we will allow the hospital to use either the definition provided by the project within the certificate of need (in States where a certificate of need is required), or other appropriate documentation provided from the hospital's project plans (such as project plans as specified in the minutes of the meetings of the hospital's board of directors).

In determining a hospital's special exceptions payment amount, as described in § 412.348(g)(8), for each cost reporting period, the cumulative payments made to the hospital under the capital prospective payment system are compared to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to the capital prospective payment system. This comparison is offset by any amount by which the hospital's current year Medicare inpatient operating and capital prospective payment system payments (excluding 75 percent of its operating DSH payments) exceed its Medicare inpatient operating and capital costs (or its Medicare inpatient margin). The minimum payment level is 70 percent for all hospitals, regardless of class, as set forth in § 412.348(g)(6), for the duration of the special exceptions provision.

In order to assist our fiscal intermediaries in determining the end of the 10-year period in which an eligible hospital will no longer be entitled to receive special exception payments, § 412.348(g)(9) requires that hospitals eligible for special exception payments submit documentation to the intermediary indicating the completion date of their project (the date the project was put in use for patient care) that meets the project need and project size requirements outlined in §§ 412.348(g)(2) through (g)(5). In order for an eligible hospital to receive special exception payments, this documentation had to be submitted in writing to the intermediary by the later of October 1, 2001, or within 3 months of the end of the hospital's last cost reporting period beginning before October 1, 2001, during which a qualifying project was completed.

We did not receive any comments on this clarification.

VII. Changes for Hospitals and Hospital Units Excluded From the Acute Care Hospital Inpatient Prospective Payment System

A. Payments to Excluded Hospitals and Hospital Units (§§ 413.40(c), (d), and (f))

1. Payments to Existing Excluded Hospitals and Hospital Units

Section 1886(b)(3)(H) of the Act (as amended by section 4414 of Public Law 105–33) established caps on the target amounts for certain existing hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. For this period, the caps on the target amounts apply to the following three classes of excluded hospitals or units: psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

In accordance with section 1886(b)(3)(H)(i) of the Act and effective for cost reporting periods beginning on or after October 1, 2002, payments to these classes of existing excluded hospitals or hospital units are no longer subject to caps on the target amounts. In accordance with existing §§ 413.40(c)(4)(ii) and (d)(1)(i) and (ii), where applicable, these excluded hospitals and hospital units continue to be paid on a reasonable cost basis, and payments are based on their Medicare inpatient operating costs, not to exceed the ceiling. The ceiling will be computed using the hospital's or unit's target amount from the previous cost reporting period updated by the rate-of-increase specified in § 413.40(c)(3)(viii) of the regulations and then multiplying this figure by the number of Medicare discharges. Effective for cost reporting periods beginning on or after October 1, 2002, rehabilitation hospitals and units are no longer paid on a reasonable cost basis but will be paid under the inpatient rehabilitation facility prospective payment system. Moreover, we have proposed the establishment of a DRG-based prospective payment system for long-term care hospitals (LTCHs) (67 FR 13415). As part of this process, we proposed a 5-year transition period from reasonable cost-based reimbursement to a fully Federal prospective payment system. However, a LTCH, subject to the blend methodology, may elect to be paid based on a 100 percent of the Federal prospective rate. (See sections VII.A.3. and 4. for a more detailed discussion.)

Comment: One commenter requested clarification as to whether payment to excluded hospitals and units are subject to the TEFRA bonus and penalty provisions and continuous improvement bonuses.

Response: Certain providers that are excluded from the acute care hospital inpatient prospective payment system will continue to receive bonus/relief payments as well as continuous improvement bonus payments, when appropriate, as provided for in § 413.40(d).

Comment: With regard to the expiration of the caps on target amounts for excluded hospitals and units, a commenter requested clarification as to how the FY 2003 target rate is to be determined.

Response: Our regulations at § 413.40(c)(4)(ii) state that ''the target amount equals the hospital's target amount for the previous cost reporting period, increased by the update factor for the subject cost reporting period * * *.'' Thus, for cost reporting periods beginning in FY 2003, the hospital or

unit should use its previous year's target amount, updated by the appropriate rate-of-increase percentage.

2. Updated Caps for New Excluded Hospitals and Units

Section 1886(b)(7) of the Act establishes a payment limitation for new psychiatric hospitals and units, new rehabilitation hospitals and units, and new long-term care hospitals. A discussion of how the payment limitation was calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46019); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000); and the July 30, 1999 final rule (64 FR 41529). Under the statute, a ''new'' hospital or unit is a hospital or unit that falls within one of the three classes of hospitals or units (psychiatric, rehabilitation or long-term care) that first receives payment as a hospital or unit excluded from the acute care hospital inpatient prospective payment system on or after October 1, 1997. The amount of payment for a ''new'' hospital or unit will be determined as follows:

- Under existing § 413.40(f)(2)(ii), for the first two 12-month cost reporting periods, the amount of payment is the lesser of: (1) The operating costs per case; or (2) 110 percent of the national median (as estimated by the Secretary) of the target amounts for the same class of hospital or unit for cost reporting periods ending during FY 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital or unit first receives payments under section 1886 of the Act, as adjusted for differences in area wage levels.
- Under existing § 413.40(c)(4)(iii)(B)(4)(v), for cost reporting periods following the hospital's or unit's first two 12-month cost reporting periods, the target amount is equal to the amount determined under section 1886(b)(7)(A)(i) of the Act for the third period, updated by the applicable hospital market basket increase percentage.

The amounts included in the following table reflect the updated 110 percent of the national median target amounts for each class of new excluded hospitals and hospital units for cost reporting periods beginning during FY 2003. These figures are updated with the most recent data available to reflect the market basket increase percentage of 3.5 percent. This percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital services (as projected by CMS's Office of the Actuary based on its historical experience with the hospital inpatient prospective payment system). For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to prospective payment system reclassifications, and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	FY 2003 labor-related share	FY 2003 nonlabor-related share
Psychiatric	$ 7,054	$ 2,804
Long-Term Care	17,286	6,872

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new rehabilitation hospitals and units since they will be paid under the inpatient rehabilitation facility prospective payment system.

3. Establishment of a Prospective Payment System for Inpatient Rehabilitation Hospitals and Units

Section 1886(j) of the Act, as added by section 4421(a) of Public Law 105–33, provided the phase-in of a case-mix adjusted prospective payment system for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation hospital unit (referred to in the statute as rehabilitation facilities) for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2002, with a fully implemented prospective payment system for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) of the Act was amended by section 125 of Public Law 106–113 to require the Secretary to use a discharge as the payment unit under the prospective payment system for inpatient hospital services furnished by rehabilitation facilities and to establish classes of patient discharges by functional-related groups. Section 305 of Public Law 106–554 further amended section 1886(j) of the Act to allow rehabilitation facilities, subject to the blend methodology, to elect to be paid the full Federal prospective payment rather than the transitional period payments specified in the Act.

On August 7, 2001, we issued a final rule in the **Federal Register** (66 FR 41316) establishing the prospective payment system for inpatient rehabilitation facilities, effective for cost reporting periods beginning on or after January 1, 2002. Under the inpatient rehabilitation prospective payment system, for cost reporting periods beginning on or after January 1, 2002, and before October 1, 2002, payment will consist of 33⅓ percent of the facility-specific payment amount (based on the reasonable cost-based reimbursement methodology) and 66⅔ percent of the adjusted Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002, payment will be based entirely on the Federal prospective payment rate determined under the inpatient rehabilitation facility prospective payment system.

4. Implementation of a Prospective Payment System for Long-Term Care Hospitals

In accordance with the requirements of section 123 of Public Law 106–113, as modified by section 307(b) of Public Law 106–554, we proposed (as published in the March 22, 2002 proposed rule (67 FR 13415)) the establishment of a per discharge, DRG-based prospective payment system for long-term care hospitals as described in section 1886(d)(1)(B)(iv) of the Act for cost reporting periods beginning on or after October 1, 2002. As part of the implementation process, we proposed a 5-year transition period from reasonable cost-based reimbursement to the fully Federal prospective rate. We also proposed that certain long-term care hospitals may elect to be paid based on 100 percent of the Federal prospective rate. Under the March 22, 2002 proposed rule, a blend of the reasonable cost-based reimbursement percentage and the prospective payment Federal rate percentage would be used to determine a long-term care hospital's total payment under the prospective payment system during the transition period. We would expect long-term care hospitals to be paid under the full Federal prospective rate for cost reporting periods beginning on or after October 1, 2006. We are in the process of developing a final rule for the long-term care prospective payment system.

5. Changes in the Types of Patients Served or Inpatient Care Services That Distort the Comparability of the Cost Reporting Period to the Base Year are Grounds for Requesting an Adjustment Payment in Accordance with Section 1886(b)(4) of the Act

Section 4419(b) of Public Law 105–33 requires the Secretary to publish annually in the **Federal Register** a report describing the total amount of adjustment (exception) payments made to excluded hospitals and units, by reason of section 1886(b)(4) of the Act, during the previous fiscal year.

However, the data on adjustment payments made during the previous fiscal year are not available in time to publish a report describing the total amount of adjustment payments made to all excluded hospitals and units.

The process of requesting, adjudicating, and awarding an adjustment payment for a given cost reporting period is likely to occur over a 2-year period or longer. First, an excluded hospital or unit must file its cost report for a fiscal year with its intermediary within 5 months after the close of the fiscal year. The fiscal intermediary then reviews the cost report and issues a Notice of Program Reimbursement (NPR) in approximately 2 months after the filing of the cost report. If the hospital's operating costs are in excess of the ceiling, the hospital may file a request for an adjustment payment within 6 months from the date of the NPR. The intermediary, or CMS, depending on the type of adjustment requested, then reviews the request and determines if an adjustment payment is warranted. This determination is often not made until more than 6 months after the date the request is filed. Therefore, it is not possible to provide data in this final rule on adjustments granted for cost reports ending in the previous Federal fiscal year (that is, FY 2002), since those adjustments may not have been requested by the publication date of this final rule. However, in an attempt to provide interested parties with data on the most recent adjustments for which we do have data, we are publishing data on adjustments that were processed by the fiscal intermediaries or CMS during FY 2001.

The table below includes the most recent data available from the fiscal intermediaries and CMS on adjustment payments that were adjudicated during FY 2001. As indicated above, the adjustments made during FY 2001 only pertain to cost reporting periods ending in years prior to FY 2000. Total adjustment payments awarded to excluded hospitals and units during FY 2001 are $23,148,456. The table depicts for each class of hospital, in the aggregate, the number of adjustment requests adjudicated, the excess operating cost over the ceiling, and the amount of the adjustment payment.

Class of Hospital	Number	Excess cost over ceiling	Adjustment payment
Psychiatric	38	$23,211,026	$11,724,665
Rehabilitation	16	8,761,312	3,860,336
Long-Term Care	3	5,665,211	4,868,889
Children	3	2,696,518	1,043,565
Cancer	2	2,846,386	1,651,001

6. Technical Correction

On June 13, 2001, we published in the **Federal Register** an interim final rule (66 FR 32172) implementing section 307(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554). Section 307(a) provided for a 25-percent increase in TEFRA target amounts for long-term care hospitals ''For cost reporting periods beginning during FY 2001 * * *.'' When we addressed this provision in the interim final rule, we stated the effective date correctly in the preamble language. However, in the regulation text, we inadvertently used an incorrect effective date. We are making the conforming change to reflect the correct date in this final rule.

B. Criteria for Exclusion of Satellite Facilities From the Hospital Inpatient Prospective Payment System

Existing regulations at 42 CFR 412.22(e) define a hospital-within-a-hospital as a hospital that occupies space in the same building as another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. Section 412.22(h), relating to satellites of hospitals excluded from the acute care hospital inpatient prospective payment system, defines a satellite facility as a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. Section 412.25(e), relating to satellites of excluded hospital units, defines a satellite facility as a part of a hospital unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. Because of the similarities between the definitions of the two types of satellite facilities and the definition of a hospital-within-a-hospital, questions have been raised as to whether satellite facilities must meet the ''hospital-within-a-hospital'' criteria in § 412.22(e) regarding having a governing body, chief medical officer, medical staff, and chief executive officer that are separate from those of the hospital with which space is shared.

Although the separateness of satellite facilities of excluded hospitals and satellite facilities of excluded units of hospitals is not explicitly required under existing regulations, we believe these two types of satellite facilities are similar enough to hospitals-within-hospitals to warrant application of more closely related criteria to all of them. Specifically, satellite facilities are like hospitals-within-hospitals in that the satellites are physically located in acute care hospitals that are paid for their inpatient services under the acute care hospital inpatient prospective payment system. Moreover, both satellite facilities and hospitals-within-hospitals provide inpatient hospital care that is paid for at higher rates than would apply if the facility were treated by Medicare as a part of the acute care hospital.

In view of these facts, it is important that we establish clear criteria for ensuring that these facilities are not merely units of the acute care hospitals in which they are located, but are, in fact, organizationally and functionally separate from those hospitals. Therefore, in the May 9, 2002 proposed rule, we proposed to revise § 412.22(h)(2) to specify that, effective for cost reporting periods beginning on or after October 1, 2002, a hospital having a satellite facility would qualify for exclusion from the acute care hospital inpatient prospective payment system only if that satellite facility is: (1) Not under the authority or control of the governing body or chief executive officer of the hospital in which it is located; and (2) it furnishes inpatient care through the use of medical personnel who are not under the authority or control of the medical staff or chief medical officer of the hospital in which it is located. We also proposed to revise § 412.25(e)(2)(iii) to state that, effective for cost reporting periods beginning on or after October 1, 2002, a hospital unit having a satellite facility would qualify for exclusion from the acute care hospital inpatient prospective payment system only if the satellite facility is not under the

authority or control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the authority or control of the medical staff or chief medical officer of the hospital in which it is located.

Comment: One commenter stated that the use of the word ''authority'' in the criteria under § 412.25(e) of the proposed rule is ambiguous and unnecessary. The commenter expressed concern that the term could be construed in a manner that would undercut the ability of hospitals to provide necessary services. Therefore, the commenter believed that the word ''authority'' should be omitted from the final regulations. In addition, the commenter recommended that the most practical way to apply hospitalswithinhospitals criteria effectively to satellite facilities would be to amend § 412.22(e) to make it apply to both types of facilities or to incorporate those criteria by reference in proposed § 412.22(h)(2). The commenter believed that these revisions would be in keeping with CMS' intent and would result in a proper policy of treating hospitals-within-hospitals and satellite facilities equitably.

Response: After a review of the pertinent regulations, we agree with the commenter that the word ''authority'' should not be referenced in the regulations. We believe that deleting the reference allows for consistency between those criteria set forth for satellite facilities and those for hospitals-within-hospitals. Accordingly, in this final rule, we are revising §§ 412.22(h)(2)(iii)(A) and 412.25(e)(2)(iii)(A) to delete the word ''authority'' from the criteria.

However, we do not believe that revising § 412.22(e) to apply to both satellite facilities and hospitals-within-hospitals would be appropriate. A number of the criteria that apply to hospitals-within-hospitals would not be applicable to satellite facilities. One example is the requirement that the cost of services that the hospital-within-a-hospital receives from the ''host'' hospital is not more than 15 percent of the hospital's inpatient operating costs would not be an appropriate criterion. This criterion would not be appropriate for satellite facilities because the test would not only look at the costs incurred by the satellite facility but also at the costs incurred by the entire hospital, including both the satellite facility and the main hospital. For example, a main hospital has 100 beds and its satellite facility has 5 beds located in an acute care hospital. Since costs of the entire excluded hospital (at both the main hospital and the satellite facility) are reported on one cost report, by only looking at the costs that are shared between the satellite facility and the acute care hospital, the costs of services that the satellite facility receives from its ''host'' hospital will invariably be less than 15 percent of the costs of the entire hospital, even if all the costs of the satellite facility were incurred by the ''host'' hospital.

Comment: One commenter stated that given that long-term care hospitals and rehabilitation hospitals and units are now, or will be shortly, paid on prospective basis, the rule limiting the number of beds in a satellite facility may no longer be necessary. The commenter believed that the rules on hospitals-within-hospitals should be adequate to address CMS' concerns about payment advantage. Hence, the commenter recommended that the satellite facility rules be eliminated because they are no longer necessary and are burdensome.

Response: We have solicited comments regarding the bed limit for satellite facilities in the March 22, 2002 proposed rule to implement the long-term care hospital prospective payment system (67 FR 13464–13465). We will address the commenter's concerns along with any other comments received when we issue the final rule for the long-term care hospital prospective payment system.

C. Critical Access Hospitals (CAHs)

1. Background

Section 1820 provides for a nationwide Medicare Rural Hospital Flexibility Program (MRHF). (MRHF replaced the 7-State Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program.) Under section 1820 of the Act, as amended, certain rural providers may be designated as critical access hospitals (CAHs) under the MRHF program if they meet qualifying criteria and the conditions for designation specified in the statute. Implementing regulations for section 1820 of the Act are located at 42 CFR Part 485, Subpart F.

2. Election of Optional Payment Method

Under existing regulations at 42 CFR 413.70(b), CAHs may elect to be paid for services to their outpatients under an optional method. Facilities making this election are paid an amount for each outpatient visit that is the sum of the reasonable costs of facility services, as determined under applicable regulations, and, for professional services otherwise payable to the physician or other practitioner, 115 percent of the amounts that otherwise would be paid for the services if the CAH had not elected payment under the optional method. To enable intermediaries to make these payments accurately and to avoid possible delays in or duplications of payment, we specify in § 413.70(b)(3) that each CAH electing payment under the optional method must inform the intermediary in writing of that election annually, at least 60 days before the start of the affected cost reporting period (65 FR 47100, August 1, 2000, and 66 FR 31272, June 13, 2001).

Since the publication of this regulation, some CAHs have expressed concern that requiring a 60-day advance notice of the election of the optional payment method limits their flexibility, and have suggested that a shorter advance notice period would be appropriate. We have contacted our fiscal intermediaries to obtain feedback on the feasibility of changing the period of advance notification, since the fiscal intermediaries would need to make appropriate bill processing changes to allow any shorter time for notification of election of the optional method. Some fiscal intermediaries stated that requiring less than 60 days' advance notice is impractical, while others believed that needed changes could be made with as little as 2 weeks' advance notice. Given the diversity of feedback on this issue and our desire to allow CAHs as much flexibility as possible, in the May 9 proposed rule, we proposed to revise § 412.30(b)(3) to allow the required advance notice period to be determined by each individual fiscal intermediary for the CAHs it services, as long as the required advance notice is not less than 14 days or more than 60 days before the start of each affected cost reporting period.

Comment: Several commenters recommended that the advanced notice period for CAHs to elect the all-inclusive billing option be set firmly at 30 days rather than allowing the fiscal intermediaries to choose a timeframe ranging from 15 days to 60 days. One commenter recommended retaining the 60-day notice to fiscal intermediaries. Another commenter stated that the implementation of such flexibility could pose problems and requested that intermediaries be required to communicate due dates effectively to CAHs. The commenters expressed concern that, by allowing each intermediary to set the period for advance notice confusion could arise, as well as result in different policies could be created across the country.

Response: We have reviewed the commenters' concerns with regard to our proposal to allow the fiscal intermediaries to set the timeframe for election of the optional payment method for CAHs. We agree that, by allowing this type of flexibility, there exists the possibility of confusion between the fiscal intermediaries and the CAHs. In addition, we recognize that various policies might be established across the country, instead of one national policy. Therefore, we believe that to help provide some stability and uniformity to this policy, it would be in the best interest of all concerned if a definite period of time is set for the CAHs to notify their intermediaries of their decision to elect the optional payment method. Accordingly, in light of the commenters concerns and input from the intermediaries, we believe that a sufficient amount of time for CAHs to notify their fiscal intermediaries of an election of the optional payment method is 30 days before the beginning of the affected cost reporting period. We believe this will give the fiscal intermediaries enough time so that payments can be made accurately, avoiding possible delays in, or duplication of, payment.

Accordingly, in this final rule, we are revising § 413.70(b)(3)(i) to state that the CAH's election of the optional payment method must be made to the fiscal intermediary 30 days prior to the start of the affected cost reporting period.

3. Use of the Resident Assessment Instrument (RAI) by CAHs

Among the existing regulations implementing section 1820 of the Act are specific conditions that a hospital must meet to be designated as a CAH. To help protect the health and safety of Medicare patients who are being furnished post-hospital skilled nursing facility (SNF) level of care in a CAH, our regulations require CAHs to comply with some, but not all, of the Medicare SNF conditions of participation at 42 CFR Part 483, Subpart B. Specifically, the regulations at § 485.645(d) provide that in order for a CAH to use its beds to provide post-hospital SNF care, the CAH must be in substantial compliance with nine of the SNF requirements contained in Part 483, Subpart B. Included among the nine requirements are requirements for comprehensive assessments, comprehensive care plans, and discharge planning as specified in § 483.20(b), (k), and (l). (We note that the existing § 485.645(d)(6) incorrectly cites these regulation cross-references as ''§ 483.20(b), (d), and (e).'' When we revised § 483.20 on December 23, 1997 (63 FR 53307), we inadvertently did not make conforming cross-reference changes in § 485.645(d)(6). In the May 9, 2002 proposed rule, we proposed to make these conforming cross-reference changes.) Section 483.20(b) provides that a facility must make a comprehensive assessment of a resident's needs using the resident assessment instrument (RAI), specified by the State, on all its swing-bed patients.

We have received inquiries regarding the need for CAHs to use the RAI for patient assessment and care planning. The inquirers consider the RAI a lengthy and burdensome instrument and pointed out that CMS currently does not require CAHs to report data from the RAI for quality or payment purposes.

We required former RPCHs to use the RAI for the assessment of swing-bed patients to avoid the possibility of negative outcomes that might extend the length of stays in these hospitals, which provided limited services. In addition, we believed that the use of the RAI would help to ensure that patient needs are met when patients are in the facility for an extended period of time. In addition, swing-bed hospitals were not required to use any patient assessment instrument because we believed that the hospital conditions of participation included requirements that were appropriate safeguards to protect the health and safety of Medicare patients. Currently, the regulations at § 483.20(f) require all long-term care facilities to collect and submit assessment data from the RAI to the State for quality and payment purposes. There are no such collection and submission requirements for CAHs.

We have gathered information from the provider community, State surveyors, and staff involved in the development of quality indicators and prospective payment system rates for SNFs to determine the feasibility of continuing to require CAHs to comply with the requirement for use of the RAI for patient assessments. Based on the information received, we can identify no specific patient benefits involved in requiring CAHs to use the RAI for patient assessment purposes.

In the interest of reducing burden, where possible, and based on our analysis of the current significance of the requirement for use of the RAI for patient assessments in CAHs, we proposed in the May 9, 2002 proposed rule to eliminate the requirement for CAHs to complete an RAI believing it to be appropriate and would not jeopardize patient health and safety. A CAH would still be required to capture assessment data for its SNF patients but would have the flexibility to document the assessment data in the medical record in a manner appropriate for its facility. We believe there are sufficient additional safeguards in the CAH regulations to ensure the health and safety of each SNF patient in a CAH. The facility would still be required to develop a comprehensive care plan for each SNF patient that includes measurable objectives and a timetable to meet a patient's medical, nursing, and psychosocial needs that are identified in an assessment. Also, a post-discharge plan of care would address post-hospital care needs of the patient. All of this information (assessment, plan of care, and discharge plans) must be maintained in the patient's medical record.

We proposed to revise § 485.645 to specify that CAHs are required to complete a comprehensive assessment, comprehensive care plan, and discharge plan in accordance with the requirements of § 483.20(b), (k), and (l), except that the CAH is not required to use the RAI specified by the State, and is not required to comply with the requirements for frequency, scope, and number of assessments prescribed in § 413.343(b).

Comment: Fifteen commenters fully supported the elimination of the requirement that CAHs complete a lengthy patient assessment form for swing-bed patients, stating that the completion of the 400 plus question comprehensive assessment was an onerous and administrative burden, considering the RAI is not used for payment or quality purposes.

Response: We appreciate the commenters' support. As we stated in the proposed rule, we believe there are sufficient safeguards in the CAH regulations to ensure the health and safety of each swing-bed patient in a CAH. The facility would still be required to develop a comprehensive care plan for each swing-bed patient that includes measurable objectives and a timetable to meet a patient's medical, nursing, and psychosocial needs that are identified in an assessment.

Comment: One commenter disagreed with the elimination of the requirement. The commenter stated that CMS' failure to provide the basis for its decision to eliminate the RAI for CAHs violates the Administrative Procedure Act (APA). Further, the commenter stated that removing the RAI requirement would jeopardize quality of care for swing-bed patients in CAHs.

Response: In order to promulgate a substantive rule, the APA requires the agency to observe notice-and-comment rulemaking procedures, which we have

done. We believe that in the May 9, 2002 proposed rule, we clearly stated the issue and provided rationale for proposing the change.

Currently, all long-term care facilities are required to collect and submit assessment data to the State from the RAI for quality and payment purposes. There are no such collection and submission requirements for CAHs in the existing Medicare conditions of participation. On average, patients stay 10 days in a CAH swing bed. However, patients in SNFs have an average length of stay of approximately 25 days and patients in a nursing facility stay, on average, 230 days in a calendar year. The Medicare RAI assessment schedule for SNFs requires that the initial assessment be performed during days 1 through 5 of a patient's stay, but may be performed as late as days 6 through 8, termed ''grace days'', which gives staff additional flexibility in conducting the assessments. The initial assessment is used to assign patients to a resource utilization group (RUG), the case-mix group classification grouping that is used in establishing payments for the first 14 days of care. Subsequently, periodic assessments through the patient's stay at a SNF are performed to determine the RUG assignment and payment rate.

We believe that the commenter's concern that the removal of the RAI requirement for CAH's would jeopardize quality of care is unfounded. At this time, we believe that the quality of care interest in a CAH is better served by eliminating a requirement in which a very limited staff resource is required to complete a document with 400 plus questions for each swing-bed patient and from which data are not submitted to CMS, or compared with other facilities. Also, the existing requirement for a post-discharge plan of care would address post-hospital care needs of the patient.

We emphasize that the focus of the proposed rule was not to make major revisions to swing-bed requirements for CAHs. The proposal was to only eliminate the use of a specific form, the RAI tool. CAHs would still be required to complete comprehensive assessments on their swing-bed patients.

Comment: One commenter stated that quality of care measurements for swing-beds should be consistent and compatible to the measurement system used by nursing homes. The commenter suggested that a quality indicators program should be implemented in all facilities with swing beds.

Response: Quality measures currently are not calculated for CAHs because there are no data submitted to CMS to calculate. Further, even if data were available, the calculation of quality measures requires assessments to be conducted on days 5 and 14. The average length of stay in a CAH, which is 10 days, is inconsistent with this process.

CMS plans to develop an assessment tool in the future that will have a ''modular format'' whereby a provider with shorter patient stays would be able to collect a smaller set of data. In the future, we may consider whether or not it is appropriate and feasible to require CAHs to use and submit data from this specific format.

Comment: One commenter stated that there is no monitoring of compliance with conditions of participation in any swing beds. The commenter stated that surveys are infrequently conducted and when they are conducted, they are announced. The commenter also suggested that CMS apply the current long-term care transfer rule to all swing beds.

Response: We acknowledge that the monitoring and survey issues addressed by the commenters are important issues. However, the issues are outside the purview of this rule. The commenter's concerns will be shared with our survey and certification group.

VIII. MedPAC Recommendations

We have reviewed the March 1, 2002 report submitted by MedPAC to Congress and have given it careful consideration in conjunction with the policies set forth in this document. MedPAC's recommendations for payments for Medicare inpatient hospital services in its March 2002 report focused mainly on accounting for changes in input prices for the hospital market basket (Recommendation 2A) and on increases in the base rate for inpatient hospital services by applying the annual update factors (Recommendations 2B–1 and 2B–2).

In Recommendation 2A, MedPAC recommended that the Secretary should use wage and benefit proxies that most closely match the training and skill requirements of health care occupations in all input price indexes used for updating payments. MedPAC further indicated that, in determining index weights, measures specific to the health sector and to occupation categories in which health care plays a major role should be emphasized. Our decision to rebase and revise the hospital market basket, including cost category weights and price proxies, that is used in determining the update factors for payments for inpatient hospital services is presented in section IV of this final rule.

Recommendations 2B–1 and 2B–2 concerning the update factor for inpatient hospital operating costs and for hospitals and hospital distinct-part units excluded from the acute care hospital inpatient prospective payment system are discussed in Appendix B to this final rule.

IX. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at *http://www.hcfa.gov/stats/pufiles.htm.* In our May 9, 2002 proposed rule, we published a list of data files that are available for purchase (67 FR 31493 through 31495).

B. Information Collection Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to evaluate fairly whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The majority of the information collection requirements contained in this final rule are currently approved. Section IX.B.1. below lists the OMB approval numbers and the current expiration dates for the information collection requirements, referenced by specific Parts under Title 42 of the Code of Federal Regulations, in this final rule that are currently approved.

In the May 9, 2002 proposed rule, we solicited public comments on each of the information collection requirements referenced in the proposed rule that are described in section IX.B.2. of this final rule, as required under the PRA of 1995.

1. Currently Approved Requirements

Regulation references in 42 CFR	OMB approval number	Current expiration date
Part 412	0938–0691	September 30, 2002.
	0938–0050	May 31, 2004.
	0938–0573	September 30, 2002.
		October 31, 2003.
		September 30, 2002.
Part 413	0938–0050	May 31, 2004.
	0938–0667	October 31, 2002.
	0938–0477	July 31, 2005.

2. Requirements for Which Public Comment Were Sought in the May 9, 2002 Proposed Rule

Section 412.230 Criteria for an Individual Hospital Seeking Redesignation to Another Rural Area or an Urban Area

Appropriate Wage Data

As specified in § 412.230, a new hospital must accumulate and provide at least 1 year of wage data to CMS for the purposes of applying for reclassification. While this collection requirement is subject to the PRA, we believe that due to the fact that hospital's maintain this data for other business purposes or state reporting requirement, or both the burden associated with this requirement is exempt from the PRA as stipulated under 5 CFR 1320.3(b)(2) and (b)(3) or both.

In addition, while this regulatory requirement is being added, the wage data collection requirement associated with this proposed regulatory requirement is currently approved under OMB collection 0938–0573 (Medicare Geographic Reclassification Review Criteria), with a current expiration date of September 30, 2002.

Section 413.65 Requirements for a determination that a facility or an organization had provider-based status

Responsibility for Obtaining Provider-Based Determinations

Under § 413.65, a potential main provider seeking an advance determination of provider-based status for a facility that is located on the main campus of the potential main provider will be required to submit an attestation stating that the facility meets the criteria in paragraph (d) of this section and, if it is a hospital, also attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section. In addition, the provider seeking such an advance determination will be required to maintain documentation of the basis for its attestations and to make that documentation available to CMS upon request.

We estimate that the burden associated with these requirements is an average of 1.5 hours per provider, for approximately 3,000 providers per year, for an annual burden of 4,500 hours. This estimate is based on the fact that the providers currently maintain the necessary data and that minimal effort would be required to locate and review the appropriate data.

Clinical Services

The clinical services of the facility or organization seeking provider-based status and the main provider will be required to maintain an unified retrieval system (or cross reference) of the main provider for all patient medical records for those patients treated in the facility or organization.

While this collection requirement is subject to the PRA, we believe that due to the fact that hospitals maintain this data for other business purposes or state reporting requirements or both, the burden associated with this requirement is exempt from the PRA as stipulated under 5 CFR 1320.3(b)(2) and (b)(3) or both.

We did not receive any public comments on the proposed information collection and recordkeeping requirements. The total burden associated with the new and revised requirements referenced in this section are 4,500 annual hours.

3. New Requirement in This Final Rule

Section 412.304(c)(2)(i)(A) Implementation of the Capital Prospective Payment System: Election by New Hospitals To Be Paid Based on 100 Percent of the Federal Rate

This section specifies that if a new hospital elects to be paid under the capital prospective payment system based on 100 percent of the Federal rate, instead of 85 percent of its allowable Medicare inpatient hospital capital-related costs, through its cost report ending at least 2 years after the hospital accepts its first patient, the new hospital must submit a written request to the fiscal intermediary. This request must be submitted by the later of December 1, 2002, or 60 days before the beginning of its cost reporting period.

We estimate that the burden associated with these requirements is an average of 1 hour per provider, for approximately 100 providers per year, for an annual burden of 100 hours.

The new information collection and recordkeeping requirements in this final rule will be submitted to the Office of Management and Budget (OMB) for review under the authority of the PRA. These requirements will not be effective until they have been approved by OMB.

If you have any comments on the information collection and recordkeeping requirements under § 412.304(c)(2)(i)(A), please mail the copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Information Services, Information Technology Investment Management Group, Attn.: John Burke, Attn.: CMS–1203–F, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn.: Brenda Aguilar, CMS Desk Officer, Attn.: CMS–1203–F.

X. Waiver of Proposed Rulemaking

The Administrative Procedure Act generally requires that agency rules be published in the **Federal Register** as a notice of proposed rulemaking with a period for public comment (5 U.S.C. 533(b)). This notice-and-comment procedure can be waived, however, if an agency finds good cause that the procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

A. Technical Correction to Regulations Relating to DSH Adjustment Factor

On June 13, 2001, we Issued in the **Federal Register** an interim final with comment period (66 FR 32172) to

update the regulations to incorporate the changes made by section 211(b) of Public Law 106–554. Section 211(b) of Public Law 106–554 amended section 1886(d)(5)(F)(iv)(III) of the Act to revise the calculation of the DSH payment adjustment for hospitals affected by the revised thresholds as specified in section 211(a) of Public Law 106–554. These changes were effective for discharges on or after April 1, 2001, and no changes were made by section 211(b) for discharges prior to April 1, 2001. In the June 13, 2001 interim final rule with comment period, we inadvertently changed the adjustment factor for rural hospitals with fewer than 100 beds from 4 percent to 5 percent under § 412.106(d)(2)(iv)(A) for discharges occurring before April l, 2001. As indicated in section V.E.3 of this final rule, we are correcting this error

Since this change is being made to correct a technical error, we find that the notice-and-comment procedure is unnecessary, and, therefore, find good cause to waive the notice of proposed rulemaking and issue the correction as final.

B. Technical Correction to Regulations Relating to TEFRA Target Amount for Long-Term Care Hospitals

Also, in the June 13, 2001 interim final rule with comment period (66 FR 32172), we implemented section 307(a) of Public Law 106–554. Section 307(a) provided for a 25-percent increase in TEFRA target amounts for long-term care hospitals ''For cost reporting periods beginning during FY 2001 * * * .'' As indicated in section VII.A.6. of this preamble, in the June 2001 interim final rule with comment period, we stated the effective date correctly in the preamble language, but in the regulation text, we inadvertently used an incorrect effective date. We are making the conforming change to reflect the correct date in this final rule.

We find it unnecessary to undertake notice-and-comment rulemaking with regard to this change because our change merely conforms the regulation text to existing policy and provides technical correction to the regulations. It does not make any substantive changes to policy. Therefore, for good cause, we are waiving the notice-and-comment procedure with regard to this change.

C. Technical Corrections Relating to Affiliated Groups

As discussed in section V.I.3. of this preamble, we are making a technical change to the language under the definition of ''affiliated group'' under § 413.86(b) under paragraph (2) to reference the use of the more recent publications of the Graduate Medical Education Directory. Since this change updates a technical reference to an annual publication, we find the notice-and comment procedure is unnecessary, and therefore find good cause to waive the notice of proposed rulemaking and issue the correction as final.

When we issued the May 9, 2002 proposed rule, due to a typographical error, we inadvertently indicated that we proposed to make changes to § 413.86(g)(5)(iv) instead of § 413.86(g)(4)(iv) to incorporate revised provisions relating to determining the weighted number of FTE residents for hospitals that are part of the same affiliated group. As a result, we erroneously stated that we proposed to add a new paragraph under § 413.86(g)(5)(iv) and to redesignate paragraphs (g)(5)(iv), (g)(5)(v), and (g)(5)(vi) and paragraphs (g)(5)(v), (g)(5)(vi), and (g)(5)(vii), respectively, to accommodate the new paragraph. As discussed in section V.I.3. of this preamble, we are correcting these errors in this final rule. Since we are making these changes to correct a technical error, we find that the notice-and-comment procedure is unnecessary and therefore find good cause to waive the notice of proposed rulemaking and issue the correction in this final rule.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant programs-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

For the reasons stated in the preamble of this final rule, 42 CFR Chapter IV is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Part 405 is amended as follows:

1. The authority citation for Part 405, Subpart R continues to read as follows:

Authority: Secs. 205, 1102, 1814(b), 1815(a), 1833, 1861(v), 1871, 1872, 1878, and 1886 of the Social Security Act (42 U.S.C. 405, 1302, 1395f(b), 1395g(a), 1395l, 1395x(v), 1395hh, 1395ii, 1395oo, and 1395ww).

2. Section 405.1885 is amended by revising paragraph (b), redesignating paragraph (e) as paragraph (f), and adding a new paragraph (e), to read as follows:

§ 405.1885 Reopening a determination or decision.

* * * * *

(b)(1) An intermediary determination or an intermediary hearing decision must be reopened and revised by the intermediary if, within the 3-year period specified in paragraph (a) of this section, CMS—

(i) Provides notice to the intermediary that the intermediary determination or the intermediary hearing decision is inconsistent with the applicable law, regulations, CMS ruling, or CMS general instructions in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the intermediary; and

(ii) Explicitly directs the intermediary to reopen and revise the intermediary determination or the intermediary hearing decision.

(2) A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening an intermediary determination or an intermediary hearing decision under this section.

(3) Notwithstanding paragraph (b)(1)(i) of this section, CMS may direct the intermediary to reopen a particular intermediary determination or intermediary hearing decision in order to implement, for the same intermediary determination or intermediary decision—

(i) A final agency decision under §§ 405.1833, 405.1871(b), 405.1875, or 405.1877(a) of this part;

(ii) A final nonappealable court judgment; or

(iii) An agreement to settle an administrative appeal or a lawsuit.

* * * * *

(e) Notwithstanding an intermediary's discretion to reopen or not reopen an intermediary determination or an intermediary hearing decision under paragraphs (a) and (c) of this section, CMS may direct an intermediary to reopen, or not to reopen, an intermediary determination or an

intermediary hearing decision in accordance with paragraphs (a) and (c) of this section.

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

B. Part 412 is amended as follows:

1. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 412.4 [Amended]

2. In § 412.4(f)(1),the reference ''paragraph (b) or (c)'' is removed and ''paragraph (b)(1) or (c)'' is added in its place.

3. Section 412.22 is amended by—

a. Revising the introductory text of paragraph (h)(2).

b. Republishing the introductory text of paragraph (h)(2)(iii).

c. Redesignating paragraphs (h)(2)(iii)(A) through (F) as paragraphs (h)(2)(iii)(B) through (G), respectively.

d. Adding new paragraph (h)(2)(iii)(A).

The revision, republication, and addition read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(h) Satellite facilities. * * *

(2) Except as provided in paragraph (h)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

* * * * *

(iii) The satellite facility meets all of the following requirements:

(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located.

* * * * *

4. Section 412.25 is amended by—

a. Revising the introductory text of paragraph (e)(2).

b. Republishing the introductory text of paragraph (e)(2)(iii).

c. Redesignating paragraphs (e)(2)(iii)(A) through (F) as paragraphs (e)(2)(iii)(B) through (G), respectively.

d. Adding new paragraph (e)(2)(iii)(A).

The revision, republication, and addition read as follows:

§ 412.25 Excluded hospitals units: Common requirements.

* * * * *

(e) *Satellite facilities.* * * *

(2) Except as provided in paragraph (e)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care hospital inpatient prospective payment systems for any period:

* * * * *

(iii) The satellite facility meets all of the following requirements:

(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical officer of the hospital in which it is located.

* * * * *

§ 412.63 [Amended]

5. Section 412.63 is amended by—

a. In paragraph (x)(2)(i)(A), removing the phrase ''tabulating the hospital's data'' and adding in its place ''tabulating its data''.

b. Removing paragraphs (x)(3) and (x)(4).

c. Redesignating paragraph (x)(5) as paragraph (x)(3).

6. Section 412.80 is amended by revising paragraph (a)(2) to read as follows:

§ 412.80 Outlier cases: General provisions.

(a) *Basic rule.* * * *

(2) *Discharges occurring on or after October 1, 1997 and before October 1, 2001.* For discharges occurring on or after October 1, 1997 and before October 1, 2001, except as provided in paragraph (b) of this section concerning transfers, CMS provides for additional payment, beyond standard DRG payments, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services, adjusted to operating costs and capital costs by applying cost-to-charge ratios, as described in § 412.84(h), exceed the DRG payment for the case, payments for indirect costs of graduate medical education (§ 412.105), and payments for serving disproportionate share of low-income patients (§ 412.106), plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

* * * * *

7. Section 412.88 is amended by republishing the introductory text of paragraph (a) and revising paragraph (a)(1) to read as follows:

§ 412.88 Additional payment for new medical service or technology.

(a) For discharges involving new medical services or technologies that meet the criteria specified in § 412.87, Medicare payment will be:

(1) One of the following:

(i) The full DRG payment (including adjustments for indirect medical education and disproportionate share but excluding outlier payments);

(ii) The payment determined under § 412.4(f) for transfer cases;

(iii) The payment determined under § 412.92(d) for sole community hospitals; or

(iv) The payment determined under § 412.108(c) for Medicare-dependent hospitals; plus

* * * * *

8. Section 412.92 is amended by revising paragraph (c)(2), to read as follows: § 412.92

Special treatment: Sole community hospitals.

* * * * *

(c) *Terminology.* * * *

(2) The term *like hospital* means a hospital furnishing short-term, acute care. Effective with cost reporting periods beginning on or after October 1, 2002, for purposes of a hospital seeking sole community hospital designation, CMS will not consider the nearby hospital to be a like hospital if the total inpatient days attributable to units of the nearby hospital that provides a level of care characteristic of the level of care payable under the acute care hospital inpatient prospective payment system are less than or equal to 8 percent of the similarly calculated total inpatient days of the hospital seeking sole community hospital designation.

* * * * *

9. Section 412.105 is amended by—

A. Republishing the introductory text of paragraph (a).

B. Revising paragraph (a)(1).

C. Revising paragraph (f)(1)(iii)(A).

D. Revising paragraph (f)(1)(vi).

E. Amending the following cross-references in paragraph (f)(1):

i. In paragraph (f)(1)(vii), the reference ''§ 413.86(g)(12)'' is removed and ''§ 413.86(g)(13)'' is added in its place.

ii. In paragraph (f)(1)(viii), the reference ''§ 413.86 (g)(7)'' is removed and ''§ 413.86(g)(8)'' is added in its place.

iii. In paragraph (f)(1)(ix), the reference ''§ 413.86(g)(8)(i) and (g)(8)(ii) of the subchapter'' is removed and ''§ 413.86(g)(9)(i) and (g)(9)(ii) of the subchapter'' is added in its place; the reference ''§ 413.86(g)(8)(i) and (g)(8)(iii)(B) of this subchapter'' is removed and ''§ 413.86(g)(9)(i) and (g)(9)(iii)(B) of this subchapter'' is added in its place; and the reference ''§ 413.86(g)(8)(i) and (g)(8)(iii)(A) of the subchapter'' is removed and ''§ 413.86(g)(9)(i) and (g)(9)(iii)(A)'' is added it its place.

iv. In paragraph (f)(1)(x), the reference ''§ 413.86(g)(12)'' is removed and ''§ 413.86(g)(13)'' is added in its place; and the reference ''§ 413.86(g)(11)'' is removed and ''§ 413.86(g)(12)'' is added in its place.

v. In paragraph (f)(1)(xi), the reference ''§ 413.86(g)(9)'' is removed and ''§ 413.86(g)(10)'' is added in its place.

vi. In paragraph (f)(1)(xii), the reference ''§ 413.86(g)(10)'' is removed and ''§ 413.86(g)(11)'' is added in its place.

The revisions read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(a) *Basic data.* CMS determines the following for each hospital:

(1) The hospital's ratio of full-time equivalent residents (except as limited under paragraph (f) of this section) to the number of beds (as determined under paragraph (b) of this section).

(i) Except for the special circumstances for affiliated groups and new programs described in paragraphs (f)(1)(vi) and (f)(1)(vii) of this section for cost reporting periods beginning on or after October 1, 1997, and for the special circumstances for closed hospitals or closed programs described in paragraph (f)(1)(ix) of this section for cost reporting periods beginning on or after October 1, 2002, this ratio may not exceed the ratio for the hospital's most recent prior cost reporting period after accounting for the cap on the number of allopathic and osteopathic full-time equivalent residents as described in paragraph (f)(1)(iv) of this section, and adding to the capped numerator any dental and podiatric full-time equivalent residents.

(ii) The exception for new programs described in paragraph (f)(1)(vii) of this section applies to each new program individually for which the full-time equivalent cap may be adjusted based on the period of years equal to the minimum accredited length of each new program.

(iii) The exception for closed hospitals and closed programs described in paragraph (f)(1)(ix) of this section applies only through the end of the first 12-month cost reporting period in which the receiving hospital trains the displaced full-time equivalent residents.

(iv) In the cost reporting period following the last year the receiving hospital's full-time equivalent cap is adjusted for the displaced resident(s), the resident-to-bed ratio cap in paragraph (a)(1) of this section is calculated as if the displaced full-time equivalent residents had not trained at the receiving hospital in the prior year.

* * * * *

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* (1) * * *

(iii)(A) Full-time equivalent status is based on the total time necessary to fill a residency slot. No individual may be counted as more than one full-time equivalent. If a resident is assigned to more than one hospital, the resident counts as a partial full-time equivalent based on the proportion of time worked in any areas of the hospital listed in paragraph (f)(1)(ii) of this section to the total time worked by the resident. A hospital cannot claim the time spent by residents training at another hospital. A part-time resident or one working in an area of the hospital other than those listed under paragraph (f)(1)(ii) of this section (such as a freestanding family practice center or an excluded hospital unit) would be counted as a partial full-time equivalent based on the proportion of time assigned to an area of the hospital listed in paragraph (f)(1)(ii) of this section, compared to the total time necessary to fill a full-time residency slot.

* * * * *

(vi) Hospitals that are part of the same affiliated group (as defined in § 413.86(b) of this subchapter) may elect to apply the limit at paragraph (f)(1)(iv) of this section on an aggregate basis, as specified in § 413.86(g)(7) of this chapter.

* * * * *

§ 412.106 [Amended]

10. In § 412.106(d)(2)(iv)(A), the phrase ''5 percent'' is removed and the phase ''4 percent'' is added in its place.

* * * * *

11. Section 412.108 is amended by revising paragraph (b) to read as follows:

§ 412.108 Special treatment: Medicare-dependent, small rural hospitals.

* * * * *

(b) *Classification procedures.* (1) The fiscal intermediary determines whether a hospital meets the criteria specified in paragraph (a) of this section.

(2) A hospital must submit a written request along with qualifying documentation to its fiscal intermediary to be considered for MDH status based on the criterion under paragraph (a)(1)(iii)(C) of this section.

(3) The fiscal intermediary will make its determination and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation.

(4) A determination of MDH status made by the fiscal intermediary is effective 30 days after the date the fiscal intermediary provides written notification to the hospital. An approved MDH status determination remains in effect unless there is a change in the circumstances under which the status was approved.

(5) The fiscal intermediary will evaluate on an ongoing basis, whether or not a hospital continues to qualify for MDH status. This evaluation includes an ongoing review to ensure that the hospital continues to meet all of the criteria specified in paragraph (a) of this section.

(6) If the fiscal intermediary determines that a hospital no longer qualifies for MDH status, the change in status will become effective 30 days after the date the fiscal intermediary provides written notification to the hospital.

(7) A hospital may reapply for MDH status following its disqualification only after it has completed another cost reporting period that has been audited and settled. The hospital must reapply for MDH status in writing to its fiscal intermediary and submit the required documentation.

(8) If a hospital disagrees with an intermediary's determination regarding the hospital's initial or ongoing MDH status, the hospital may notify its fiscal intermediary and submit other documentable evidence to support its claim that it meets the MDH qualifying criteria.

(9) The fiscal intermediary's initial and ongoing determination is subject to review under subpart R of Part 405 of this chapter. The time required by the fiscal intermediary to review the request is considered good cause for granting an extension of the time limit for the hospital to apply for that review.

* * * * *

12. Section 412.113 is amended by revising paragraphs (c)(2)(i)(D), (c)(2)(ii), and (c)(2)(iii) to read as follows:

§ 412.113 Other payments.

* * * * *

(c) *Anesthesia services furnished by hospital employed nonphysician anesthetists or obtained under arrangements.*

* * * * *

(2)(i) * * *

(D) Each qualified nonphysician anesthetist employed by or under contract with the hospital or CAH has agreed in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.

(ii) To maintain its eligibility for reasonable cost payment under paragraph (c)(2)(i) of this section in calendar years after 1989, a qualified hospital or CAH must demonstrate prior to January 1 of each respective year that for the prior year its volume of surgical procedures requiring anesthesia service did not exceed 500 procedures; or, effective October 1, 2002, did not exceed 800 procedures.

(iii) A hospital or CAH that did not qualify for reasonable cost payment for nonphysician anesthetist services furnished in calendar year 1989 can qualify in subsequent years if it meets the criteria in paragraphs (c)(2)(i)(A), (B), and (D) of this section, and demonstrates to its intermediary prior to the start of the calendar year that it met these criteria. The hospital or CAH must provide data for its entire patient population to demonstrate that, during calendar year 1987 and the year immediately preceding its election of reasonable cost payment, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 500 procedures, or, effective October 1, 2002, did not exceed 800 procedures.

* * * * *

13. Section 412.230 is amended by adding a new paragraph (e)(2)(iii) to read as follows:

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

* * * * *

(e) *Use of urban or other rural area's wage index.* * * *

(2) *Appropriate wage data.* * * *

(iii) For purposes of this paragraph (e)(2), if a new owner does not accept assignment of the existing hospital's provider agreement in accordance with § 489.18 of this chapter, the hospital will be treated as a new provider with a new provider number. In this case, the wage data associated with the previous hospital's provider number cannot be used in calculating the new hospital's 3-year average hourly wage. Once a new hospital has accumulated at least 1 year of wage data, it is eligible to apply for reclassification on the basis of those data.

* * * * *

14. Section 412.273 is amended by—

A. Revising the section heading.

B. Revising paragraphs (b)(2)(i) and (b)(2)(ii).

C. Adding a new paragraph (b)(2)(iii).

D. Redesignating paragraph (d) as paragraph (e).

E. Adding a new paragraph (d).

The revisions and additions read as follows:

§ 412.273 Withdrawing an application, terminating an approved 3-year reclassification, or canceling a previous withdrawal or termination.

* * * * *

(b) *Request for termination of approved 3-year wage index reclassifications.* * * *

(2) *Reapplication within the approved 3-year period.*

(i) If a hospital elects to withdraw its wage index application after the MGCRB has issued its decision, it may cancel its withdrawal in a subsequent year and request the MGCRB to reinstate its wage index reclassification for the remaining fiscal year(s) of the 3-year period.

(ii) A hospital may apply for reclassification for purposes of the wage index to a different area (that is, an area different from the one to which it was originally reclassified for the 3-year period). If the application is approved, the reclassification will be effective for 3 years. Once a 3-year reclassification becomes effective, a hospital may no longer cancel a withdrawal or termination of another 3-year reclassification, regardless of whether the withdrawal or termination request is made within 3 years from the date of the withdrawal or termination.

(iii) In a case in which a hospital with an existing 3-year wage index reclassification applies to be reclassified to another area, its existing 3-year reclassification will be terminated when a second 3-year wage index reclassification goes into effect for payments for discharges on or after the following October 1.

* * * * *

(d) *Process for canceling a previous withdrawal or termination.* A hospital may cancel a previous withdrawal or termination by submitting written notice of its intent to the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year, as specified in § 412.256(a)(2).

* * * * *

15. Section 412.304 is amended by revising paragraph (c) to read as follows:

§ 412.304 Implementation of the capital prospective payment system.

* * * * *

(c) *Cost reporting periods beginning on or after October 1, 2001.*— (1) *General.* Except as provided in paragraph (c)(2) of this section, for cost reporting periods beginning on or after October 1, 2001, the capital payment amount is based solely on the Federal rate determined under §§ 412.308(a) and (b) and updated under § 412.308(c).

(2) *Payment to new hospitals.* For cost reporting periods beginning on or after October 1, 2002—

(i) A new hospital, as defined under § 412.300(b), is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost report ending at least 2 years after the hospital accepts its first patient, unless the new hospital elects to be paid under the capital prospective payment system based on 100 percent of the Federal rate.

(A) If the new hospital elects to be paid based on 100 percent of the Federal rate, the new hospital must submit a written request to the fiscal intermediary by the later of December 1, 2002 or 60 days before the beginning of its cost reporting period.

(B) Once a new hospital elects to be paid based on 100 percent of the Federal rate, it may not revert to payment at 85 percent of its allowable Medicare inpatient hospital capital-related costs.

(ii) For the third year and subsequent years, the hospital is paid based on the Federal rate as described under § 412.312.

* * * * *

16. Section 412.308 is amending by adding a new paragraph (b)(6) to read as follows:

§ 412.308 Determining and updating the Federal rate.

* * * * *

(b) *Standard Federal rate.* * * *

(6) For discharges occurring on or after October 1, 2002, the 2.1 percent reduction provided for under paragraph (b)(5) of this section is eliminated from the unadjusted standard Federal rate in effect on September 30, 2002, used to determine the Federal rate each year under paragraph (c) of this section.

* * * * *

17. Section 412.312 is amended by adding a new paragraph (e) to read as follows:

§ 412.312 Payment based on the Federal rate.

* * * * *

(e) *Payment for extraordinary circumstances.* Payment for extraordinary circumstances is made as provided for in § 412.348(f) for cost reporting periods beginning on or after October 1, 2001.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

C. Part 413 is amended as follows:

1. The authority citation for Part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

2. Section 413.40 is amended by revising paragraph (c)(4)(iii)(A)(*2*) to read as follows:

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

* * * * *

(c) * * *

(4) * * *

(iii) * * *

(A) * * *

(*2*) In the case of long-term care hospitals, for cost reporting periods beginning on or after October 1, 2000, the hospital-specific target amount is the net allowable costs in a base period increased by the applicable update factors multiplied by 1.25.

* * * * *

3. Section 413.65 is amended by—

A. Revising paragraphs (a)(1)(ii), (a)(1)(ii)(G), and (a)(1)(ii)(H).

B. Adding new paragraphs (a)(1)(ii)(J) and (a)(1)(ii)(K).

C. Revising the definition of ''Department of a provider'', ''Provider-based entity'', and ''Remote location of a hospital'' under paragraph (a)(2).

D. Revising paragraphs (b)(2), (b)(3), (c) and (d).

E. Removing paragraph (j).

F. Redesignating paragraphs (h) and (i) as paragraphs (i) and (j), respectively.

G. Redesignating paragraph (f) as paragraph (h).

H. Redesignating paragraph (e) as paragraph (f).

I. Adding a new paragraph (e).

J. Revising redesignated paragraph (f).

K. Revising the introductory text of paragraph (g) and paragraphs (g)(1), (g)(2), and (g)(7).

L. Revising redesignated paragraphs (h), (i), and (j).

M. Revising paragraph (k).

N. Redesignating paragraphs (l), (m), and (n) as paragraphs (m), (n), and (o), respectively.

O. Adding a new paragraph (l).

P. Revising the heading of redesignated paragraph (n).

Q. Revising redesignated paragraph (o).

The revisions and addition read as follows:

§ 413.65 Requirements for a determination that a facility or an organization had provider-based status.

(a) *Scope and definitions.*—(1) *Scope.* * * *

(ii) The determinations of provider-based status for payment purposes described in this section are not made as to whether the following facilities are provider-based:

* * * * *

(G) Independent diagnostic testing facilities furnishing only services paid under a fee schedule, such as facilities that furnish only screening mammography services (as defined in section 1861(jj) of the Act), facilities that furnish only clinical diagnostic laboratory tests, or facilities that furnish only some combination of these services.

(H) Facilities, other than those operating as parts of CAHs, furnishing only physical, occupational, or speech therapy to ambulatory patients, for as long as the $1,500 annual cap on coverage of physical, occupational, or speech therapy, as described in section 1833(g)(2) of the Act, remains suspended by the action of subsequent legislation.

* * * * *

(J) Departments of providers that perform functions necessary for the successful operation of the providers but do not furnish services of a type for which separate payment could be claimed under Medicare or Medicaid (for example, laundry or medical records departments).

(K) Ambulances.

(2) *Definitions.* * * *

Department of a provider means a facility or organization that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. A department of a provider may not by itself be qualified to participate in Medicare as a provider under § 489.2 of this chapter, and the Medicare conditions of participation do not apply to a department as an independent entity. For purposes of this part, the term ''department of a provider'' does not include an RHC or, except as specified in paragraph (n) of this section, an FQHC.

* * * * *

Provider-based entity means a provider of health care services, or an RHC as defined in § 405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this section. A provider-based entity comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. A provider-based entity may, by itself, be qualified to participate in Medicare as a provider under § 489.2 of this chapter, and the Medicare conditions of participation do apply to a provider-based entity as an independent entity.

* * * * *

Remote location of a hospital means a facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A remote location of a hospital comprises both the specific physical facility that serves as the site of services for which separate payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. The Medicare conditions of participation do not apply to a remote location of a hospital as an independent entity. For purposes of this part, the term ''remote location of a hospital'' does not include a satellite facility as defined in § 412.22(h)(1) and § 412.25(e)(1) of this chapter.

(b) *Procedure for obtaining provider-based determinations.* * * *

(2) If a facility was treated as provider-based in relation to a hospital

or CAH on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until the start of the hospital's first cost reporting period beginning on or after July 1, 2003. The requirements, limitations, and exclusions specified in paragraphs (d), (e), (f), (h), and (i) of this section will not apply to that hospital or CAH until the start of the hospital's first cost reporting period beginning on or after July 1, 2003. For purposes of this paragraph (b)(2), a facility is considered as provider-based on October 1, 2000 if, on that date, it either had a written determination from CMS that it was provider-based, or was billing and being paid as a provider-based department or entity of the hospital.

(3)(i) Except as specified in paragraphs (b)(2) and (b)(5) of this section, if a potential main provider seeks a determination of provider-based status for a facility that is located on the campus of the potential main provider, the provider would be required to submit an attestation stating that the facility meets the criteria in paragraph (d) of this section and if it is a hospital, also attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section. The provider seeking such a determination would also be required to maintain documentation of the basis for its attestations and to make that documentation available to CMS and to CMS contractors upon request.

(ii) If the facility is not located on the campus of the potential main provider, the provider seeking a determination would be required to submit an attestation stating that the facility meets the criteria in paragraphs (d) and (e) of this section, and if the facility is operated as a joint venture or under a management contract, the requirements of paragraph (f) or paragraph (h) of this section, as applicable. If the potential main provider is a hospital, the hospital also would be required to attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section. The provider would be required to supply documentation of the basis for its attestations to CMS at the time it submits its attestations.

(iii) Whenever a provider submits an attestation of provider-based status for an on-campus facility or organization, as described in paragraph (b)(3)(i) of this section, CMS will send the provider written acknowledgment of receipt of the attestation, review the attestation for completeness, consistency with the criteria in this section, and consistency with information in the possession of CMS at the time the attestation is received, and make a determination as to whether the facility or organization is provider-based.

(iv) Whenever a provider submits an attestation of provider-based status for an off-campus facility or organization, as described in paragraph (b)(3)(ii) of this section, CMS will send the provider written acknowledgment of receipt of the attestation, review the attestation for completeness, consistency with the criteria in this section, consistency with the documentation submitted with the attestation and consistency with information in the possession of CMS at the time the attestation is received, and make a determination as to whether the facility or organization is provider-based.

* * * * *

(c) *Reporting of material changes in relationships.* A main provider that has had one or more facilities or organizations considered provider-based also may report to CMS any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that would affect the provider-based status of the facility or organization.

(d) *Requirements applicable to all facilities or organizations.* Any facility or organization for which provider-based status is sought, whether located on or off the campus of a potential main provider, must meet all of the following requirements to be determined by CMS to have provider-based status:

(1) *Licensure.* The department of the provider, the remote location of a hospital, or the satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, the remote location of a hospital, or the satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, the remote location of a hospital, or the satellite facility under a single license. If a State health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers in a State finds that a particular facility or organization is not part of a provider, CMS will determine that the facility or organization does not have provider-based status.

(2) *Clinical services.* The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:

(i) Professional staff of the facility or organization have clinical privileges at the main provider.

(ii) The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

(iii) The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

(iv) Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

(v) Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

(vi) Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

(3) *Financial integration.* The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of a facility or organization that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility or organization other than a hospital department are reported in the appropriate cost center or cost centers of the main provider, and the financial status of any provider-based facility or organization is incorporated and readily identified in the main provider's trial balance.

(4) *Public awareness.* The facility or organization seeking status as a department of a provider, a remote location of a hospital, or a satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

(5) *Obligations of hospital outpatient departments and hospital-based entities.* In the case of a hospital outpatient department or a hospital-based entity, the facility or organization must fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section.

(e) *Additional requirements applicable to off-campus facilities or organizations.* Except as described in paragraphs (b)(2) and (b)(5) of this section, any facility or organization for which provider-based status is sought that is not located on the campus of a potential main provider must meet both the requirements in paragraph (d) of this section and all of the following additional requirements, in order to be determined by CMS to have provider-based status.

(1) *Operation under the ownership and control of the main provider.* The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

(i) The business enterprise that constitutes the facility or organization is 100 percent owned by the provider.

(ii) The main provider and the facility or organization seeking status as a department of the provider, a remote location of a hospital, or a satellite facility have the same governing body.

(iii) The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the provider where it is based.

(iv) The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the facility or organization.

(2) *Administration and supervision.* The reporting relationship between the facility or organization seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its existing departments, as evidenced by compliance with all of the following requirements:

(i) The facility or organization is under the direct supervision of the main provider.

(ii) The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the entity—

(A) Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and its existing departments; and

(B) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

(iii) The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are—

(A) Contracted out under the same contract agreement; or

(B) Handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

(3) *Location.* The facility or organization is located within a 35-mile radius of the campus of the hospital or CAH that is the potential main provider, except when the requirements in paragraph (e)(3)(i), (e)(3)(ii), or (e)(3)(iii) of this section are met:

(i) The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under § 412.106 of this chapter) greater than 11.75 percent or is described in § 412.106(c)(2) of this chapter implementing section 1886(e)(5)(F)(i)(II) of the Act and is—

(A) Owned or operated by a unit of State or local government;

(B) A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(C) A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

(ii) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period—

(A) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;

(B) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or

(C) If the facility or organization is unable to meet the criteria in paragraph (e)(3)(ii)(A) or paragraph (e)(3)(ii)(B) of this section because it was not in operation during all of the 12-month period described in paragraph (e)(3)(ii) of this section, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in paragraph (e)(3)(ii) of this section, accounted for at least 75 percent of the patients served by the main provider.

(iv) A facility or organization may qualify for provider-based status under this section only if the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, in adjacent States.

(v) An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in § 412.62(f)(1)(iii) of this chapter, and has fewer than 50 beds, as determined under § 412.105(b) of this chapter, is not subject to the criteria in paragraphs (e)(3)(i) through (e)(3)(iii) of this section.

(f) *Provider-based status for joint ventures.* In order for a facility or organization operated as a joint venture to be considered provider-based, the facility or organization must—

(1) Be partially owned by at least one provider'

(2) Be located on the main campus of a provider who is a partial owner;

(3) Be provider-based to that one provider whose campus on which the facility or organization is located; and

(4) Also meet all the requirements applicable to all provider-based facilities and organizations in paragraph (d) of this section. For example, where a provider has jointly purchased or jointly created a facility under joint venture arrangements with one or more other providers, and the facility is not located on the campus of the provider or the campus of any other provider engaged in the joint venture arrangement, no party to the joint venture arrangement can claim the facility as provider-based.

(g) *Obligations of hospital outpatient departments and hospital-based entities.*

(1) Hospital outpatient departments located either on or off the campus of the hospital that is the main provider must comply with the antidumping rules in §§ 489.20 (l), (m), (q), and (r) and § 489.24 of this chapter.

(2) Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined under the rules of Part 414 of this chapter.

* * * * *

(7) When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, and the treatment is not required to be provided by the antidumping rules in § 489.24 of this chapter, the hospital must provide written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability).

(i) The notice must be one that the beneficiary can read and understand.

(ii) If the exact type and extent of care needed is not known, the hospital may furnish a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based.

(iii) The hospital may furnish an estimate based on typical or average charges for visits to the facility, while stating that the patient's actual liability will depend upon the actual services furnished by the hospital.

(iv) If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative.

(v) In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the antidumping rules of § 489.24 of this chapter, notice, as described in this paragraph (g)(7), must be given as soon as possible after the existence of an emergency has been ruled out or the emergency condition has been stabilized.

* * * * *

(h) *Management contracts.* A facility or organization that is not located on the campus of the potential main provider and otherwise meets the requirements of paragraphs (d) and (e) of this section, but is operated under management contracts, must also meet all of the following criteria:

(1) The main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule established by regulations at part 414 of this chapter. Other than staff that may be paid under such a Medicare fee schedule, the main provider may not utilize the services of ''leased'' employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) that are directly involved in the delivery of patient care.

(2) The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph (e)(2)(iii) of this section.

(3) The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph (e)(2)(ii) of this section.

(4) The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

(i) *Furnishing all services under arrangement.* A facility or organization may not qualify for provider-based status if all patient care services furnished at the facility or organization are furnished under arrangements.

(j) *Inappropriate treatment of a facility or organization as provider-based.—(1) Determination and review.* If CMS learns that a provider has treated a facility or organization as provider-based and the provider did not request a determination of provider-based status from CMS under paragraph (b)(3) of this section and CMS determines that the facility or organization did not meet the requirements for provider-based status under paragraphs (d) through (i) of this section, as applicable (or, in any period before the effective date of these regulations, the provider-based requirements in effect under Medicare program regulations or instructions), CMS will—

(i) Issue notice to the provider in accordance with paragraph (j)(3) of this section, adjust the amount of future payments to the provider for services of the facility or organization in accordance with paragraph (j)(4) of this section, and continue payments to the provider for services of the facility or organization only in accordance with paragraph (j)(5) of this section; and

(ii) Except as otherwise provided in paragraphs (b)(2), (b)(5), or (j)(2) of this section, recover the difference between the amount of payments that actually was made and the amount of payments that CMS estimates should have been made, in the absence of compliance with the provider-based requirements, to that provider for services at the facility or organization for all cost reporting periods subject to reopening in accordance with §§ 405.1885 and 405.1889 of this chapter.

(2) *Exception for good faith effort.* CMS will not recover any payments for any period before the beginning of the hospital's first cost reporting period beginning on or after January 10, 2001, if, during all of that period—

(i) The requirements regarding licensure and public awareness in paragraphs (d)(1) and (d)(4) of this section were met;

(ii) All facility services were billed as if they had been furnished by a department of a provider, a remote location of a hospital, a satellite facility, or a provider-based entity of the main provider; and

(iii) All professional services of physicians and other practitioners were billed with the correct site-of-service indicator, as described in paragraph (g)(2) of this section.

(3) *Notice to provider.* If CMS determines that a facility or organization was inappropriately treated as provider-based, CMS will issue written notice to the provider that payments for past cost reporting periods may be reviewed and recovered as described in paragraph (j)(1)(ii) of this section, and that future payments for services in or of the facility or organization will be adjusted as described in paragraph (j)(4) of this section.

(4) *Adjustment of payments.* If CMS determines that a facility or organization was inappropriately treated as provider-based, CMS will adjust future payments to the provider or the facility or organization, or both, to estimate the amounts that would be paid for the same services furnished by a freestanding facility.

(5) *Continuation of payment.* (i) The notice of denial of provider-based status sent to the provider will ask the provider to notify CMS in writing, within 30 days of the date the notice is issued, of whether the provider intends to seek a determination of provider-based status for the facility or organization under this section or whether the facility or organization (or, where applicable, the practitioners who staff the facility or organization) will be seeking to enroll and meet other requirements to bill for services in a freestanding facility.

(ii) If the provider indicates that it will not be seeking a determination for the facility or organization under this section or that the facility or organization or its practitioners will not be seeking to enroll, or if CMS does not receive a response within 30 days of the date the notice was issued, all payment under this paragraph (j)(5) will end as of the 30th day after the date of notice.

(iii) If the provider indicates that it will be seeking a determination for the facility or organization under this section or that the facility or organization or its practitioners will be seeking to meet enrollment and other requirements for billing for services in a freestanding facility, payment for services of the facility or organization will continue, at the adjusted amounts described in paragraph (j)(4) of this section, for as long as is required for all billing requirements to be met (but not longer than 6 months) if the provider or the facility or organization or its practitioners—

(A) Submits, as applicable, a complete request for a determination of provider-based status or a complete enrollment application and provide all other required information within 90 days after the date of notice; and

(B) Furnishes all other information needed by CMS to make a determination regarding provider-based status or process the enrollment application, as applicable, and verifies that other billing requirements are met.

(v) If the necessary applications or information are not provided, CMS will terminate all payment to the provider, facility, or organization as of the date CMS issues notice that necessary applications or information have not been submitted.

(k) *Temporary treatment as provider-based.* If a provider submits a complete attestation of compliance with the requirements for provider-based status for a facility or organization that has not previously been found by CMS to have been inappropriately treated as provider-based under paragraph (j) of this section, the provider may bill and be paid for services of the facility or organization as provider-based from the date it submits the attestation and any required supporting documentation until the date that CMS determines that the facility or organization does not meet the provider-based rules. If CMS subsequently determines that the requirements for provider-based status are not met, CMS will recover the difference between the amount of payments that actually was made since the date the complete attestation of compliance with provider-based requirements was submitted and the amount of payments that CMS estimates should have been made in the absence of compliance with the provider-based requirements. For purposes of this paragraph (k), a complete attestation of compliance with provider-based requirements is one that includes all information needed to permit CMS to make a determination under paragraph (b)(3) of this section.

(l) *Correction of errors.* (1) If CMS determines that a facility or organization that had previously been determined to be provider-based under this section no longer qualifies for provider-based status, and the failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that the provider did report to CMS under paragraph (c) of this section, treatment of the facility or organization as provider-based ceases with the date that CMS determines that the facility or organization no longer qualifies for provider-based status.

(2) If CMS determines that a facility or organization that had previously been determined to be provider-based under this section no longer qualifies for provider-based status, and if the failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that the provider did not report to CMS under paragraph (c) of this section, CMS will take the actions with respect to notice to the provider, adjustment of payments, and continuation of payment described in paragraphs (j)(3), (j)(4), and (j)(5) of this section, and will recover past payments to the provider to the extent described in paragraph (j)(1)(ii) of this section.

(m) *Status of Indian Health Service and Tribal facilities and organizations.*

* * * * *

(n) *FQHCs and ''look alikes.''* * * *

(o) *Effective date of provider-based status.*—(1) *General rule.* Provider-based status for a facility or organization is effective on the earliest date all of the requirements of this part have been met.

(2) *Inappropriate treatment as provider-based or not reporting material change.* Effective for any period on or after October 1, 2002 (or, in the case of facilities or organizations described in paragraph (b)(2) of this section, for cost reporting periods starting on or after July 1, 2003), if a facility or organization is found by CMS to have been inappropriately treated as provider-based under paragraph (j) of this section for those periods, or previously was determined by CMS to be provider-based but no longer qualifies as provider-based because of a material change occurring during those periods that was not reported to CMS under paragraph (c) of this section, CMS will not treat the facility or organization as provider-based for payment purposes until CMS has determined, based on documentation submitted by the provider, that the facility or organization meets all requirements for provider-based status under this part.

4. Section 413.70 is amended by revising paragraph (b)(3)(i) to read as follows:

§ 413.70 Payment for services of a CAH.

* * * * *

(b) *Payment for outpatient services furnished by CAH.* * * *

(3) *Election to be paid reasonable costs for facility services plus fee schedule for professional services.* (i) A CAH may elect to be paid for outpatient services in any cost reporting period under the method described in paragraphs (b)(3)(ii) and (b)(3)(iii) of this section. This election must be made in writing, made on an annual basis, and delivered to the fiscal intermediary servicing the CAH at least 30 days before the start of each affected cost reporting period. An election of this

payment method, once made for a cost reporting period, remains in effect for all of that period and applies to all services furnished to outpatients during that period.

* * * * *

5. Section 413.86 is amended by—

A. Revising the definition of ''Affiliated group'' under paragraph (b).

B. Adding definitions of ''Affiliation agreement'' and ''Shared rotational arrangement'' in alphabetical order under paragraph (b).

C. Revising the last sentence of paragraph (e)(5)(i), introductory text.

D. Revising paragraph (e)(5)(i)(B).

E. Adding a new paragraph (e)(5)(i)(C).

F. Revising paragraph (f)(2).

G. Republishing the introductory text of paragraph (g)(4) and revising paragraph (g)(4)(iv).

H. Redesignating paragraphs (g)(7) through (g)(12) as paragraphs (g)(8) through (g)(13), respectively.

I. Adding a new paragraph (g)(7).

J. Amending the following cross-references:

i. In paragraph (g)(5)(vi), ''paragraph (g)(8)'' is removed and ''paragraph (g)(9)'' is added in its place.

ii. In paragraph (g)(6), ''paragraph (g)(12)'' is removed and ''paragraph (g)(13)'' is added in its place.

iii. In redesignated paragraphs (g)(8)(iv) and (g)(8)(v), ''paragraph (g)(7)'' is removed and ''paragraph (g)(8)'' is added in its place.

iv. In redesignated paragraph (g)(9)(i), ''paragraph (g)(8)'' is removed and ''paragraph (g)(9)'' is added in its place.

v. In the introductory text of redesignated paragraph (g)(9)(iii), ''paragraph (g)(8)(iii)(B)'' is removed and ''paragraph (g)(9)(iii)(B)'' is added in its place; and ''paragraph (g)(8)(iii)(A)'' is removed and ''paragraph (g)(9)(iii)(A)'' is added in its place.

vi. In redesignated paragraph (g)(9)(iii)(A)(*2*), ''paragraph (g)(8)(iii)(B)(*2*)'' is removed and ''paragraph (g)(9)(iii)(B)(*2*)'' is added in its place.

vii. In the introductory text of redesignated paragraph (g)(12), ''paragraph (g)(11)(i) through (g)(11)(vi)'' is removed and ''paragraph (g)(12)(i) through (g)(12)(vi)'' is added in its place.

The additions and revisions read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) *Definitions.* * * *

Affiliated group means—

(1) Two or more hospitals that are located in the same urban or rural area (as those terms are defined in § 412.62(f) of this subchapter) or in contiguous area and meet the rotation requirement in paragraph (g)(7)(ii) of this section.

(2) Two or more hospitals that are not located in the same or in a contiguous urban or rural area, but meet the rotation requirement in paragraph (g)(7)(ii) of this section, and are jointly listed—

(i) As the sponsor, primary clinical site or major participating institution for one or more programs as these terms are used in the most current publication of the *Graduate Medical Education Directory;* or

(ii) As the sponsor or is listed under ''affiliations and outside rotations'' for one or more programs in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs.*

(3) Two or more hospitals that are under common ownership and, effective for all affiliation agreements beginning July 1, 2003, meet the rotation requirement in paragraph (g)(7)(ii) of this section.

Affiliation agreement means a written, signed, and dated agreement by responsible representatives of each respective hospital in an affiliated group, as defined in this section, that specifies—

(1) The term of the agreement (which, at a minimum is one year), beginning on July 1 of a year;

(2) Each participating hospital's direct and indirect GME FTE caps in effect prior to the affiliation;

(3) The total adjustment to each hospital's FTE caps in each year that the affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to one hospital's direct and indirect FTE caps that is offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount;

(4) The adjustment to each participating hospitals' FTE counts resulting from the FTE resident's (or residents') participation in a shared rotational arrangement at each hospital participating in the affiliated group for each year the affiliation agreement is in effect. This adjustment to each participating hospital's FTE count is also reflected in the total adjustment to each hospital's FTE caps (in accordance with paragraph (3) of this definition); and

(5) The names of the participating hospitals and their Medicare provider numbers.

* * * * *

Shared rotational arrangement means a residency training program under which a resident(s) participates in training at two or more hospitals in that program.

(e) *Determining per resident amounts for the base period.*

(5) Exceptions—(i) *Base period for certain hospitals.* * * * The per resident amount is based on the lower of the amount specified in paragraph (e)(5)(i)(A) or in paragraph (e)(5)(i)(B) of this section, subject to the provisions of paragraph (e)(5)(i)(C) of this section.

(B) Except as specified in paragraph (e)(5)(i)(C) of this section—

(*1*) For base periods that begin before October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter.

(*2*) For base periods beginning on or after October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated using all per resident amounts (including primary care and obstetrics and gynecology and nonprimary care) and FTE resident counts from the most recently settled cost reports of those teaching hospitals.

(C) If, under paragraph (e)(5)(i)(B)(*1*) or (e)(5)(i)(B)(*2*) of this section, there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value of per resident amounts of all hospitals located in the same census region as that term is used in § 412.62(f)(1)(i) of this chapter.

* * * * *

(f) *Determining the weighted number of FTE residents.* * * *

(2) No individual may be counted as more than one FTE. A hospital cannot claim the time spent by residents training at another hospital. Except as provided in paragraphs (f)(3) and (f)(4) of this section, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

* * * * *

(g) *Determining the weighted number of FTE residents.* * * *

(4) For purposes of determining direct graduate medical education payment—

* * * * *

(iv) Hospitals that are part of the same affiliated group (as described under paragraph (b) of this section) may elect to apply the limit on an aggregate basis as described under paragraph (g)(7) of this section.

* * * * *

(7) A hospital may receive a temporary adjustment to its FTE cap, which is subject to the averaging rules under paragraph (g)(5)(iii) of this section, to reflect residents added or subtracted because the hospital is participating in an affiliated group (as defined under paragraph (b) of this section). Under this provision—

(i) Each hospital in the affiliated group must submit the affiliation agreement, as defined under paragraph (b) of this section, to the CMS fiscal intermediary servicing the hospital and send a copy to CMS's Central Office no later than July 1 of the residency program year during which the affiliation agreement will be in effect.

(ii) Each hospital in the affiliated group must have a shared rotational arrangement, as defined in paragraph (b) of this section, with at least one other hospital within the affiliated group, and all of the hospitals within the affiliated group must be connected by a series of such shared rotational arrangements.

(iii) During the shared rotational arrangements under an affiliation agreement, as defined in paragraph (b) of this section, more than one of the hospitals in the affiliated group must count the proportionate amount of the time spent by the resident(s) in its FTE resident counts. No resident may be counted in the aggregate as more than one FTE.

(iv) The net effect of the adjustments (positive or negative) on the affiliated hospitals' aggregate FTE cap for each affiliation agreement must not exceed zero.

(v) If the affiliation agreement terminates for any reason, the FTE cap of each hospital in the affiliated group will revert to the individual hospital's pre-affiliation FTE cap that is determined under the provisions of paragraph (g)(4) of this section.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

D. Part 485 is amended as follows:

1. The authority citation for Part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Act (42 U.S.C. 1302 and 1396hh).

2. In § 485.645, the introductory text of paragraph (d) is republished and paragraph (d)(6) is revised, to read as follows.

§ 485.645 Special requirements for CAH providers of long-term care services (''swing-beds'').

* * * * *

(d) *SNF services.* The CAH is substantially in compliance with following SNF requirements contained in Subpart B of Part 483 of this chapter.

* * * * *

(6) Comprehensive assessment, comprehensive care plan, and discharge planning (§ 483.20(b), (k), and (l) of this chapter, except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under § 483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in § 413.343(b) of this chapter).

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare— Hospital Insurance)

Dated: July 24, 2002.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 24, 2002.

Tommy G. Thompson,

Secretary.

[**Editorial Note:** The following Addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Schedule of Standardized Amounts Effective With Discharges Occurring On or After October 1, 2002 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2002

I. Summary and Background

In this Addendum, we are setting forth the amounts and factors for determining prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs. We are also setting forth rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system.

For discharges occurring on or after October 1, 2002, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the acute care hospital inpatient prospective payment system will be based on 100 percent of the Federal national rate.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or 75 percent of the updated hospital-specific rate based on FY 1996 costs per discharge, plus the greater of 25 percent of the updated FY 1982 or FY 1987 hospital-specific rate or 50 percent of the Federal DRG payment rate. Section 213 of Public Law 106–554 amended section 1886(b)(3) of the Act to allow all SCHs to rebase their hospital-specific rate based on their FY 1996 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. MDHs do not have the option to use their FY 1996 hospital-specific rate.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 50 percent of a Puerto Rico rate and 50 percent of a Federal national rate. (See section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2003. The changes, to be applied prospectively effective with discharges occurring on or after October 1, 2002, affect the calculation of the Federal rates. In section III. of this Addendum, we discuss our changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2003. Section IV. of this Addendum sets forth our changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system for FY 2003. The tables to which we refer in the preamble to this final rule are presented in section V. of this Addendum.

II. Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for FY 2003

The basic methodology for determining prospective payment rates for hospital inpatient operating costs is set forth at § 412.63. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the factors used for determining the prospective payment rates.

In summary, the standardized amounts set forth in Tables 1A and 1C of section V. of this Addendum reflect—

- Updates of 2.95 percent for all areas (that is, the market basket percentage increase of 3.5 percent minus 0.55 percentage points);
- An adjustment to ensure the DRG recalibration and wage index update and changes are budget neutral, as provided for under sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act, by applying new budget neutrality adjustment factors to the large urban and other standardized amounts;
- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY

2002 budget neutrality factor and applying a revised factor;

- An adjustment to apply the new outlier offset by removing the FY 2002 outlier offsets and applying a new offset; and
- An adjustment in the Puerto Rico standardized amounts to reflect the application of a Puerto Rico-specific wage index.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

Section 1886(d)(2)(A) of the Act required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contained a detailed explanation of how base-year cost data were established in the initial development of standardized amounts for the acute care hospital inpatient prospective payment system.

Section 1886(d)(9)(B)(i) of the Act required us to determine the Medicare target amounts for each hospital located in Puerto Rico for its cost reporting period beginning in FY 1987. The September 1, 1987 final rule (52 FR 33043, 33066) contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates.

The standardized amounts are based on per discharge averages of adjusted hospital costs from a base period or, for Puerto Rico, adjusted target amounts from a base period, updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. Sections 1886(d)(2)(B) and (d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, and costs to hospitals serving a disproportionate share of low-income patients.

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, in making payments under the acute care hospital inpatient prospective payment system, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Since October 1, 1997, when the market basket was last revised, we have considered 71.1 percent of costs to be labor-related for purposes of the acute care hospital inpatient prospective payment system. As discussed in section IV. of the preamble to this final rule, we are not revising the labor share of the standardized amount (the proportion adjusted by the wage index). The average labor share in Puerto Rico is 71.3 percent. We are revising the discharge-weighted national standardized amount for Puerto Rico to reflect the proportion of discharges in large urban and other areas from the FY 2001 MedPAR file.

2. Computing Large Urban and Other Area Average Standardized Amounts

Sections 1886(d)(2)(D) and (d)(3) of the Act require the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (d)(9)(C)(i) of the Act, the average standardized amount per discharge must be determined for hospitals located in large urban and other areas in Puerto Rico. In accordance with section 1886(b)(3)(B)(i) of the Act, the large urban average standardized amount is 1.6 percent higher than the other area average standardized amount.

Section 1886(d)(2)(D) of the Act defines ''urban area'' as those areas within a Metropolitan Statistical Area (MSA). A ''large urban area'' is defined as an urban area with a population of more than 1 million. In addition, section 4009(i) of Public Law 100–203 provides that a New England County Metropolitan Area (NECMA) with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. Urban areas that do not meet the definition of a ''large urban area'' are referred to as ''other urban areas.'' Areas that are not included in MSAs are considered ''rural areas'' under section 1886(d)(2)(D) of the Act. Payment for discharges from hospitals located in large urban areas will be based on the large urban standardized amount. Payment for discharges from hospitals located in other urban and rural areas will be based on the other standardized amount.

Based on the latest available population estimates published by the Bureau of the Census, 63 areas meet the criteria to be defined as large urban areas for FY 2003. These areas are identified in Table 4A.

3. Updating the Average Standardized Amounts

Under section 1886(d)(3)(A) of the Act, we update the average standardized amounts each year. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are updating the large urban areas' and the other areas' average standardized amounts for FY 2003 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XVIII) of the Act specifies that the update factor for the standardized amounts for FY 2003 is equal to the market basket percentage increase minus 0.55 percentage points for hospitals in all areas.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2003 is 3.5 percent. Thus, for FY 2003, the update to the average standardized amounts equals 2.95 percent for hospitals in all areas.

As in the past, we are adjusting the FY 2002 standardized amounts to remove the effects of the FY 2002 geographic reclassifications and outlier payments before applying the FY 2003 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliers. We then apply the new offsets to the standardized amounts for outliers and geographic reclassifications for FY 2003.

We do not remove the prior budget neutrality adjustment because, in accordance with section 1886(d)(4)(C)(iii) of the Act, estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

Although the update factors for FY 2003 are set by law, we are required by section 1886(e)(3) of the Act to report to the Congress our initial recommendation of update factors for FY 2003 for both prospective payment hospitals and hospitals excluded from the prospective payment system. We have included our final recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) in Appendix B to this final rule.

4. Other Adjustments to the Average Standardized Amounts

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II. of the preamble, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are making a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. This provision is required by section 4410(b) of Public Law 105–33 to be budget neutral.

In addition, we are required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. As discussed in section II.D. of this final rule, we are approving one new technology for add-on payments in FY 2003. We estimate that the total add-on payments for this new technology will be $74.8 million.

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that DRG

reclassification and recalibration of the relative weights be budget neutral, and the requirement in section 1886(d)(3)(E) of the Act that the updated wage index be budget neutral, we used FY 2001 discharge data to simulate payments and compared aggregate payments using the FY 2002 relative weights and wage index to aggregate payments using the FY 2003 relative weights and wage index, plus the additional add-on payments for the new technology. The same methodology was used for the FY 2002 budget neutrality adjustment, except for the new technology add-on budget neutrality adjustment. Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.993209. We also adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 0.994027. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2002 budget neutrality adjustments.

In addition, we will apply these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 2002. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

Comment: One commenter questioned this budget neutrality calculation in the proposed rule and pointed out that the total numbers of cases in Table 7A, showing FY 2001 MedPAR records assigned to version 19 GROUPER DRGs, was different than the total number of cases in Table 7B, which shows FY 2001 MedPAR records assigned to version 20 GROUPER DRGs. The commenter noted that a similar discrepancy occurred in the FY 2002 final rule, yet there has been no discrepancy in the past. Based on the discrepancy in total cases, the commenter was concerned that the budget neutrality calculation may be incorrect.

Response: The commenter correctly points out a discrepancy in the source files used to produce Tables 7A and 7B for the FY 2002 final rule and the FY 2003 proposed rule. We have corrected this discrepancy in this final rule. The source of the discrepancy was the removal of statistical outliers for DRG recalibration. Statistical outliers are defined as cases with charges per case and charges per day beyond 3 standard deviations from the DRG mean. In the proposed rule, Table 7A had statistical outliers removed based on the GROUPER version 19 DRG assignment, and Table 7B had statistical outliers removed based on the GROUPER version 20 DRG assignment. In this final rule, we have removed only statistical outliers based on version 20 DRG assignment from both Table 7A and Table 7B.

This discrepancy did not affect the budget neutrality calculation, however. This calculation uses only cases remaining after trimming statistical outliers based on GROUPER version 20 DRG assignment. Payments for these remaining cases are then compared using first their version 19 GROUPER DRG assignment, then their version 20 DRG assignment.

b. Reclassified Hospitals—Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the standardized amount or the wage index, or both.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the acute care hospital inpatient prospective payment system after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. To calculate this budget neutrality factor, we used FY 2001 discharge data to simulate payments, and compared total prospective payments (including IME and DSH payments) prior to any reclassifications to total prospective payments after reclassifications. Based on these simulations, we are applying an adjustment factor of 0.991095 to ensure that the effects of reclassification are budget neutral.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 2002 budget neutrality adjustment factor. We note that the FY 2003 adjustment reflects FY 2003 wage index and standardized amount reclassifications approved by the MGCRB or the Administrator, and the effects of section 1886(d)(10)(D)(v) of the Act to extend wage index reclassifications for 3 years.

c. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for ''outlier'' cases, cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed loss cost threshold amount. To determine whether the costs of a case exceed the fixed loss threshold, a hospital's cost-to-charge ratio is applied to the total covered charges for the case to convert the charges to costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the threshold.

Under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amounts by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases.

i. FY 2003 outlier fixed loss cost thresholds. For FY 2002, the threshold is equal to the prospective payment rate for the DRG, plus any IME and DSH payments plus $21,025. The marginal cost factor (the percent of costs paid after costs for the case exceed the threshold) is 80 percent.

For FY 2003, we proposed to establish a fixed loss cost outlier threshold equal to the prospective payment rate for the DRG plus any IME and DSH payments, and any add-on payments for new technology, plus $33,450. This single threshold would be applicable for cases to qualify for both operating and capital outlier payments. We proposed to maintain the marginal cost factor at 80 percent.

To calculate the FY 2003 outlier thresholds, we simulated payments by applying FY 2003 rates and policies to the March 2002 update of the FY 2001 MedPAR file and the March 2002 update of the Provider-Specific File. Therefore, it was necessary to inflate the charges on the MedPAR claims by 2 years, from FY 2001 to FY 2003, in order to determine the appropriate FY 2003 thresholds.

Previously, inflation factors have been calculated by measuring the percent change in costs using the two most recent available cost report files. For example, the FY 2002 threshold was determined using the rate of cost increase measured using costs from hospitals' FY 1998 and FY 1999 cost reports. However, at the time of the proposed rule, the FY 2000 cost reports were not available to produce an updated cost inflation factor due to processing delays associated with implementing the hospital outpatient prospective payment system.

As discussed in the May 9, 2002 proposed rule, rather than use the rate of cost increase from hospitals' FY 1998 and FY 1999 cost reports to project the rate of increase from FY 2001 to FY 2003, we proposed to use a 3-year moving average of the rate of change in costs for prior years to estimate the annual rates of inflation from FY 2001 to FY 2003. The calculation was discussed thoroughly in the proposed rule (67 FR 31510).

Based on this methodology, we proposed a 2-year cost inflation factor of 15.0 percent to inflate FY 2001 charges to FY 2003, determined by multiplying the annual projected inflation factors for FYs 2002 and 2003 of 1.0655 and 1.0793.

We pointed out that, using actual FY 2001 cases, our analysis indicated that this 3-year moving average methodology would have resulted in FY 2002 outlier payments very close to 5.1 percent of total operating DRG payments and outlier payments.

Comment: Several commenters stated that the proposed 59 percent increase in the outlier threshold is an enormous increase based on old data and a new methodology, and as a result, puts hospitals at even greater risk for high-cost cases. One commenter wrote that this type of unpredictability makes sound management difficult.

The commenters also believed that the proposed outlier policy, if implemented in a budget neutral manner, has the effect of reducing hospital payments by 1.87 percent, nearly wiping out any inflationary increase paid through the market basket increase.The commenters stated that, without more recent data and better rationale, the outlier threshold should remain unchanged at the FY 2002 level of $21,025.

Response: Our objective in setting the outlier threshold is to set it at a level that is projected to result in outlier payments during the upcoming Federal fiscal year that are equal to 5.1 percent of operating DRG payments. In accordance with section 1886(d)(3)(B) of the Act, we reduce the standardized amounts by 5.1 percent to account for the projected 5.1 percent paid to outliers. This adjustment is intended to ensure that outlier payments are budget neutral: Total payments after making outlier payments are equal to what total payments would have been without making any outlier payments. Therefore, if our projections of outlier payments are perfectly accurate, there is no net change in total hospital payments related to outlier policy.

We believe the reference to reducing hospital payments by 1.87 percent relates to the fact that, for FY 2002, outlier payments will be greater than 5.1 percent of total DRG payments, and if outlier payments are projected to equal 5.1 percent of total DRG payments in FY 2003, hospitals will not receive the additional payments they otherwise would if outlier payments exceeded 5.1 percent. The statute requires that the outlier offset to the average standardized amounts equal the projected proportion of outlier payments relative to total operating DRG payments. Therefore, if we offset the average standardized amounts by 5.1 percent to account for outlier payments, we must set the outlier threshold at a level we project will result in outlier payments equal to 5.1 percent of total operating DRG payments.

Moreover, we believe that in order to maintain the fiscal integrity of the Medicare Trust Fund, we must set the FY 2003 outlier threshold so that, based on our best estimate, the proportion of FY 2003 outlier payments relative to total DRG payments is projected to equal the offset of the average standardized amounts.

As discussed in further detail below, we now estimate FY 2002 outlier payments to be 6.9 percent of total DRG payments, using the FY 2002 threshold of $21,025. Therefore, we estimate that we will be paying approximately $1.5 billion more in outlier payments during FY 2002 than we would have if our outlier projections had been perfectly accurate (outlier payments 1.9 percentage points higher relative to total DRG payments of approximately $76 billion). The table below demonstrates that actual outlier payments since 1997 have exceeded the 5.1 percent offset by an aggregate of 11.2 percentage points, equating with approximately $8.5 billion in higher than anticipated payments. However, analysis over a longer time period demonstrates that years in which CMS has paid more than projected in outlier payments are offset by years in which CMS has paid less than projected.

Year	Payments in excess of 5.1 percent (percentage points)
1997	0.4
1998	1.4
1999	2.5
2000	2.5
2001	2.6
2002	1.8

Based on available information (which was not available at the time we set the FY 2003 outlier thresholds), we now estimate that an outlier threshold of $30,525 would have resulted in outlier payments equal to 5.1 percent of total DRG payments for FY 2002. Therefore, barring any drastic reductions in hospital charges per case, maintaining the FY 2003 fixed loss outlier threshold at $21,025, while offsetting the standardized amount by only 5.1 percent, would almost certainly guarantee that FY 2003 total payments after outlier payments and the offset would exceed what total payments would have been without making any outlier payments or offset.

Comment: Numerous commenters added that the proposed methodology for determining the estimate of cost inflation is flawed and, as a result, the new threshold is too high. The commenters expressed concern that increasing the threshold too fast will seriously undermine hospitals' ability to continue to care for high-cost frail and elderly patients.

The commenters stated that the proposed 2-year cost inflation factor of 15.0 percent from FY 2001 to FY 2003 is more than triple the rate of change of cost inflation in FY 1999. The commenters also stated that this increase is also markedly different and significantly higher than all other government projections of cost inflation. For instance, they pointed out that, in its March 2002 report, MedPAC measured hospital cost inflation at 4.8 percent for the time period FY 2001 to FY 2003; the Office of Management and Budget has projected cost inflation for the overall economy at a rate of 2.2 percent for FY 2003; and CMS' market basket for that time period is a 6.6 percent increase.

Several commenters focused on the fact that, rather than proposing to calculate the inflation factor based on an annual rate of change, we proposed to calculate it using the difference in the annual rate of change (second derivative). The commenters submitted analysis indicating this proposed methodology was more volatile in its estimates than alternative approaches. In addition, the commenters stated that our data were outdated and therefore unreliable.

The commenters proposed using one of three alternatives:

- Three-year moving average of annual rates of change in costs rather than a 3-year average of the differences in the annual rates of change in costs (as proposed). The projected increase in hospital cost inflation from FY 2001 to FY 2003 using this method would be 4.1 percent.
- CMS' usual method in predicting cost inflation, but substituting a 4-year lag in data rather than the typical 3-year lag due to the lack of FY 2000 cost reports. The projected increase in hospital cost inflation from FY 2001 to FY 2003 would be 4.8 percent.
- Changes as measured in the hospital market basket index. The projected increase in hospital cost inflation from FY 2001 to FY 2003 would be 7.1 percent.

The commenters stated that the alternative that most closely approximates CMS' usual method is the 4-year lag approach. The commenters also recognized that the simulations of the market basket index approach they submitted tracks most closely with actual cost increases. The commenters stated that this method would result in a new outlier threshold between $26,254 and $27,810, which the commenters believe is a much more realistic increase.

One commenter noted that determining the outlier threshold is dependent not only on changes in costs per case, but is also dependent on hospital charges and cost-to-charge ratios.

Response: Our proposed methodology took into account that the most recent cost data we had available was approximately 3 years old by including a factor to measure the rate of growth in the annual change in costs per case. Using data from hospitals' cost reports, we calculated average annual rates of change to project cost growth from FYs 1999 through 2003. We believe this approach was preferable to a simple average rate of change when projecting over a 4-year time span because, by including a factor to measure the rate of change we account for the observed trend in cost growth over recent periods. We do not dispute that this methodology results in inflation factors higher than other estimates, including the market basket used to update the acute inpatient prospective payment system. However, we point out that our analysis in the proposed rule showed that, if this methodology had been used to estimate the threshold for FY 2002, it would have resulted in FY 2002 outlier payments much closer to 5.1 percent of total DRG payments than we are currently estimating (67 FR 31510).

Nevertheless, we understand the commenters' concerns that our methodology to estimate cost inflation for purposes of setting the outlier threshold is much higher than other, more established methodologies and we considered the alternatives suggested by the commenters. Each of the three alternative are based on projecting cost increases.

As noted above, commenters indicated they believe a FY 2003 threshold between $26,254 and $27,810 would be realistic. However, we believe, based on our analysis of MedPAR data, that this threshold would be significantly inaccurate. To illustrate, we used actual MedPAR data for the past 2.5 years to determine what thresholds would have resulted in a 5.1 percent outlier payout for FYs 2000, 2001 and 2002.

Fiscal year	Threshold actually applied	Threshold that would have paid out 5.1 percent	Actual payout percentage
2000	$14,050	$21,825	7.6
2001	17,550	26,200	7.7
2002*	21,025	30,525*	6.9

*Using March 2002 Update of Fiscal Year 2002 MedPAR Cases.

This table shows that, had we set the threshold each of the last 3 fiscal years at a level that would have paid out 5.1 percent based on data now available, the FY 2002 threshold would have actually been $30,525. Based on this analysis, we believe a threshold of no more than $27,810, as suggested by the commenters, would be likely to result in payments in excess of 5.1 percent.

Outlier payments are determined by multiple variables that change at different rates over time. As described above, to determine whether a case qualifies as an outlier, the hospital's cost-to-charge ratio is applied to the covered charges (which are adjusted for the area wage index applicable to the area where the hospital is located) of a case to estimate the costs. The estimated costs for the case are then compared to the outlier threshold to determine whether the case qualifies for outlier payments.

Based on our analysis above, we believe that, due to current trends in hospital charging practices, using inflation factors based on annual cost growth results in underestimating the percentage of outlier payments. That is, if charges are growing at a faster rate than costs, inflating FY 2001 charges by the observed rate of change in costs will underestimate FY 2003 charges, thereby resulting in outlier payments greater than 5.1 percent. Therefore, we analyzed the rate of change in covered charges per case over the past 3 years. Because charge data are available from claims data in the MedPAR file, they are more up-to-date than cost data taken from the cost reports.

FY	Covered charge/case	Percentage change in charge/case
1999	$15,215	.....
2000	16,376	7.63
2001	18,015	10.00

This table illustrates the substantial increase recently in the growth of charges, indicating that charges have indeed been increasing faster than costs. Because charges serve as the basis to estimate costs for purposes of identifying outlier cases, higher than expected increases in charges would lead to more cases qualifying for outlier payments than expected (and more of the costs of qualifying cases in excess of the threshold).

Over time, cost-to-charge ratios will reflect the differential increase in charges. However, due to the delay in processing the FY 2000 cost reports, combined with the dramatically different rates of change in charges and costs, we believe it is appropriate, at least as far as determining the outlier thresholds for FY 2003, to change from our past methodology of basing the inflation factor on the rate of change in costs, and instead rely on the rate of change in charges. Therefore, we are not adopting our proposed methodology.

Instead, we have determined that, for purposes of setting a FY 2003 outlier threshold that we project will result in outlier payments of 5.1 percent of total DRG payments, the most appropriate methodology to use is to inflate charges using a 2-year average annual rate of change in charges per case. The 2-year average annual rate of change in charges per case from FY 1999 to FY 2000, and from FY 2000 to FY 2001, is 8.8199 percent annually, or 17.6398 percent over 2 years. Applying this charge inflation factor to FY 2001 cases results in a fixed loss outlier threshold of $33,560.

We believe inflating charges by the 2-year average annual rate of change in charges per case is an appropriate revision to our prior inflation methodology used to set the threshold. That is, our analysis described above indicates that a 2-year average annual rate of change based on charges results in a threshold that is more consistent with what our analysis indicates recent thresholds would have resulted in actual outlier payments approximating 5.1 percent of actual total operating DRG payments. In addition, our analysis above demonstrates that charges have been growing at a much faster rate than recent estimates of cost growth, indicating that the average rate of change in charges will produce a more appropriate inflation factor at this time. We have selected a 2-year average rate of change in charges (from FY 1999 to FY 2000 and from FY 2000 to FY 2001) rather than simply a 1-year rate of change in order to account for the greater variability of charges (due to the fact that hospitals have greater latitude in setting their charges than they do over their costs). We would point out that this analysis is based on recent data and does not reflect upon previous analysis used to support the use of cost inflation factors used in the Medicare cost reports.

Using this revised methodology for setting the charge inflation factors for FY 2003, we are establishing a fixed loss cost outlier threshold equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $33,560. This single threshold would be applicable to qualify for both operating and capital outlier payments. We are also maintaining the marginal cost factor for cost outliers at 80 percent.

Comment: Two commenters recommended that we increase the FY 2002 threshold by the market basket inflation factor, then develop a new threshold using our previous cost inflation methodology when FY 2000 cost reports come available later this year.

Response: Based on our analysis of where prior years' thresholds would have been set if we knew at the time we set the thresholds what we know now, and our analysis showing the higher rate of change in charges than in costs, we are revising our methodology to establish the FY 2003 outlier thresholds to reflect the rate of change in charges. We believe this will establish the thresholds at an appropriate level using more recent data. Therefore, we are not accepting the commenters' recommendation.

Comment: Some commenters predicted that, as a result of the large increase in the threshold from FY 2002, outlier payments would fall well below 5.1 percent.

Response: We have taken the commenters' concerns and our further analysis into account in our methodology to set the FY 2003 threshold. Based on our analysis as described above, we disagree with the commenters' prediction.

Comment: One commenter attributed the high percentage of outlier payments relative to DRG payments to the increasing costs of medical technology, for which the commenter argued that there is no effective payment solution.

Response: Our analysis indicates the higher than estimated outlier payments are attributable to charges rising faster than our inflation estimates. This may be associated with increasing costs and utilization of medical technology, as the commenter suggested. This effect would eventually be reflected in the DRG weights and the market basket estimate.

However, we would point out that our analysis above indicates that charges are rising much faster than costs. This would indicate that costs estimated by applying cost-to-charge ratios from past periods to charges from current periods would result in estimated costs in excess of actual costs. Therefore, we disagree that rising costs due to new technology is the reason outlier payments have been higher than projected.

Comment: Some commenters argued that the delay in processing cost reports is interrupting the gradually declining trend in cost-to-charge ratios, leading to higher cost estimates than anticipated.

Response: Our analysis shows that, despite the delay in processing cost reports alluded to above, the average cost-to-charge ratios have continued to decline. We note there is always a lag between the timeframe from which the cost-to-charge ratios are taken and the period to which they are applied to charges. We do not have any evidence that the higher than expected outlier payments result from any extra lag in updating cost-to-

charge ratios due to the delay in processing the cost reports.

Comment: Some commenters referenced a joint letter from CMS' Center for Medicare Management, Office of Financial Management, issued April 22, 2002, on the issue of the correct calculation of hospital cost-to-charge ratios, as indicative of potential erroneous cost-to-charge ratios influencing the calculation of the outlier threshold.

Response: The joint letter clarified instructions to all fiscal intermediaries on calculating the cost-to-charge ratios in response to isolated instances where we were made aware they had been calculated incorrectly. We have examined the cost-to-charge ratios and do not believe the issue addressed in the joint letter is systemic, and therefore, it should not materially affect our outlier threshold calculations.

Comment: One commenter recommended increasing the estimated outlier payment percentage from 5.1 percent to 6.0 percent, the upper bound permissible under the statute. The commenter believed the proposed outlier change would cause an inequitable redistribution and that increasing the outlier target would address this inequity.

Response: Although reducing the outlier threshold would result in a higher outlier payout, and we have authority under section 1886(d)(5)(A)(iv) of the Act to set an outlier target of up to 6.0 percent, we do not believe this approach would be appropriate. As noted previously, section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amounts by the projected proportion of total DRG payments made to outlier cases. Therefore, adopting this suggestion would result in lower standardized amounts for all cases, reducing payments for hospitals that do not generally receive as high a proportion of outlier payments as other hospitals as a result of the lower standardized amount. These low-outlier hospitals would be negatively impacted by reducing the standardized amount without the benefit of continued high outlier payments.

Comment: Commenters also suggested reducing the marginal cost factor below 80 percent. One commenter suggested raising the marginal cost factor from 80 percent to 90 percent. This commenter stated such a change would redistribute the negative impact of increasing the threshold in a more equitable manner.

Response: Reducing the marginal cost factor would result in a lower outlier threshold (so more cases would qualify for outlier payments) but would also result in lower outlier payments per outlier case. While we considered this approach to alleviate the impact of the proposed increase in the outlier threshold, we decided not to adopt it without further analysis (the commenter presented no assessment of the impacts of such a change, for example). We note that the current 80 percent marginal cost factor was established for FY 1994 (from 75 percent) to further focus Medicare's cost outlier payments on the costliest cases (59 FR 45367). This change was consistent with a recommendation by the Prospective Payment Assessment Commission (MedPAC's predecessor) based on its analysis of outlier policy. We believe it would be necessary to conduct further analysis of the impacts of changing the marginal cost factor before making such a change in the marginal cost factor. Conversely, increasing the marginal cost factor would result in either raising the outlier threshold (which means fewer cases would qualify for outlier payments) or raising the offset to the standardized amount, or both. We believe that an 80 percent marginal cost factor and 5.1 percent outlier target appropriately target payments to extremely high cost cases and, at the same time, provide adequate compensation to nonoutlier cases.

ii. Other changes concerning outliers. In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated outlier thresholds so that outlier payments are projected to equal 5.1 percent of total operating DRG payments plus outlier payments. In accordance with section 1886(d)(3)(B), we reduced the FY 2003 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers.

As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2003 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.4 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors to be applied to the standardized amounts for FY 2003 were as follows:

	Operating standardized amounts	Capital federal rate
National	0.949004	0.945957
Puerto Rico	0.982910	0.980994

Based on simulations of payments using updated data, the final outlier adjustment factors applied to the standardized amounts for FY 2003 are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948999	0.946924
Puerto Rico	0.981651	0.979669

As in the proposed rule, we apply the outlier adjustment factors after removing the effects of the FY 2002 outlier adjustment factors on the standardized amounts.

To determine whether a case qualifies for outlier payments, we apply hospital-specific cost-to-charge ratios to the total covered charges for the case. Operating and capital costs for the case are calculated separately by applying separate operating and capital cost-to-charge ratios, then these costs are combined to compare with the fixed-loss outlier threshold.

For those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios lower than 0.194 or greater than 1.258, or capital cost-to-charge ratios lower than 0.012 or greater than 0.163, statewide average ratios would be used to calculate costs to determine whether a hospital qualifies for outlier payments.[1] Table 8A in section V. of this Addendum contains the updated statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals for which the fiscal intermediary is unable to compute a hospital-specific cost-to-charge ratio within the above range. These statewide average ratios replace the ratios published in the August 1, 2001 final rule (66 FR 40083). Table 8B contains comparable statewide average capital cost-to-charge ratios. We note that the cost-to-charge ratios in Tables 8A and 8B will be used during FY 2003 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or are outside the ranges noted above.

iii. FY 2001 and FY 2002 outlier payments. In the August 1, 2001 final rule (66 FR 39942), we stated that, based on available data, we estimated that actual FY 2001 outlier payments would be approximately 6.2 percent of actual total DRG payments. This was computed based on simulations using the March 2001 update of the Provider-Specific File and the March 2001 update of the FY 2000 MedPAR file (discharge data for FY 2000 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2001 bills but instead reflected the application of FY 2001 rates and policies to available FY 2000 bills.

Our current estimate, using available FY 2001 bills, is that actual outlier payments for FY 2001 were approximately 7.7 percent of actual total DRG payments. Thus, the data indicate that, for FY 2001, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2001 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 2001). Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the acute care hospital inpatient prospective payment system, we do not plan to recoup money and make retroactive adjustments to outlier payments for FY 2001.

We currently estimate that actual outlier payments for FY 2002 will be approximately 6.9 percent of actual total DRG payments, 1.8 percentage points higher than the 5.1 percent we projected in setting outlier policies for FY 2002. This estimate is based on simulations using the March 2001 update of the Provider-Specific File and the March 2001 update of the FY 2001 MedPAR file (discharge data for FY 2001 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2002 by applying FY 2002 rates and policies to available FY 2001 bills.

5. FY 2003 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions.

[1] This range represents 3.0 standard devitations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals.

Table 1A contains the two national standardized amounts that are applicable to all hospitals, except hospitals in Puerto Rico. As described in section II.A.1. of this Addendum, we are not revising the labor share of the national standardized amount from 71.1 percent.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount and the national other standardized amount (as set forth in Table 1A). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C. This table also includes the Puerto Rico standardized amounts. The labor share applied to the Puerto Rico standardized amount is 71.3 percent.

B. Adjustments for Area Wage Levels and Cost of Living

Tables 1A and 1C, as set forth in this Addendum, contain the labor-related and nonlabor-related shares that will be used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of this preamble, we discuss the data and methodology for the FY 2003 wage index. The wage index is set forth in Tables 4A, 4B, 4C, and 4F of this Addendum.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2003, we are adjusting the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

TABLE OF COST-OF-LIVING ADJUSTMENT FACTORS, ALASKA AND HAWAII HOSPITALS

Alaska—All areas	1.25
Hawaii:	
County of Honolulu	1.25
County of Hawaii	1.165
County of Kauai	1.2325
County of Maui	1.2375
County of Kalawao	1.2375

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section II. of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section V. of this Addendum contains the relative weights that we will use for discharges occurring in FY 2003. These factors have been recalibrated as explained in section II. of the preamble.

D. Calculation of Prospective Payment Rates for FY 2003

General Formula for Calculation of Prospective Payment Rates for FY 2003

The operating prospective payment rate for all hospitals paid under the acute-care, short-term inpatient prospective payment system located outside of Puerto Rico, except SCHs and MDHs, equals the Federal rate based on the amounts in Table 1A.

The prospective payment rate for SCHs and MDHs equals the higher of the applicable Federal rate from Table 1A or the hospital-specific rate as described below. The prospective payment rate for Puerto Rico equals 50 percent of the Puerto Rico rate plus 50 percent of the national rate from Table 1C.

1. Federal Rate

For discharges occurring on or after October 1, 2002 and before October 1, 2003, except for SCHs, MDHs, and hospitals in Puerto Rico, payment under the acute-care inpatient prospective payment system is based exclusively on the Federal national rate.

The payment amount is determined as follows:

Step 1—Select the appropriate average standardized amount considering the location of the hospital (large urban or other) (see Table 1A in section V. of this Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified (see Tables 4A, 4B, and 4C of section V. of this Addendum).

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if appropriate, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the appropriate DRG (see Table 5 of section V. of this Addendum).

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or, for FY 2003, 75 percent of the updated hospital-specific rate based on FY 1996 costs per discharge, plus the greater of 25 percent of the updated FY 1982 or FY 1987 hospital-specific rate or 25 percent of the Federal DRG payment rate.

Section 1886(d)(5)(G) of the Act provides that MDHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rate based on FY 1982 and FY 1987 cost per discharge. MDHs do not have the option to use their FY 1996 hospital-specific rate.

Hospital-specific rates have been determined for each of these hospitals based on either the FY 1982 cost per discharge, the FY 1987 cost per discharge or, for SCHs, the FY 1996 cost per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); the September 4, 1990 final rule (55 FR 35994); and the August 1, 2000 final rule (65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the budget neutrality adjustment factor (that is, by 0.994027) as discussed in section II.A.4.a. of this Addendum. The resulting rate is used in determining the payment rate an SCH or MDH would be paid for its discharges beginning on or after October 1, 2002.

b. Updating the FY 1982, FY 1987, and FY 1996 Hospital-Specific Rates for FY 2003

We are increasing the hospital-specific rates by 2.95 percent (the hospital market basket percentage increase minus 0.55 percentage points) for SCHs and MDHs for FY 2003. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs equal the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2003, is the market basket rate of increase minus 0.55 percentage points. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2003, is the market basket rate of increase minus 0.55 percentage points.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2002 and Before October 1, 2003

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate adjusted average standardized amount considering the large urban or other designation of the hospital (see Table 1C of section V. of the Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate Puerto Rico-specific wage index (see Table 4F of section VI. of the Addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the result in Step 3 by 50 percent.

Step 5—Multiply the amount from Step 4 by the appropriate DRG relative weight (see Table 5 of section V. of the Addendum).

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1C of section V. of the Addendum) by the appropriate national wage index (see Tables 4A and 4B of section VI. of the Addendum).

Step 2—Add the amount from Step 1 and the nonlabor-related portion of the national average standardized amount.

Step 3—Multiply the result in Step 2 by 50 percent.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 of section V. of the Addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico.

III. Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2003

The prospective payment system for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period and during a 10-year transition period extending through FY 2001, acute care hospital inpatient capital-related costs were paid on the basis of an increasing proportion of the capital prospective payment system Federal rate and a decreasing proportion of a hospital's historical costs for capital.

The basic methodology for determining Federal capital prospective rates is set forth in regulations at §§ 412.308 through 412.352. Below we discuss the factors that we used to determine the capital Federal rate for FY 2003, which will be effective for discharges occurring on or after October 1, 2002. The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except ''new'' hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate.

For FY 1992, we computed the standard Federal payment rate for capital-related costs under the prospective payment system by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the standard Federal rate, as provided in § 412.308(c)(1), to account for capital input price increases and other factors. Also, § 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the Federal rate to total capital payments under the Federal rate. In addition, § 412.308(c)(3) requires that the Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exceptions under § 412.348. Furthermore, § 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral. For FYs 1992 through 1995, § 412.352 required that the Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the rate made in FY 1996 as a result of the revised policy of paying for transfers. In the FY 1998 final rule with comment period (62 FR 45966), we implemented section 4402 of Public Law 105–33, which requires that, for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted standard Federal rate is reduced by 17.78 percent. As we explained in section VI.D. of the preamble of this final rule, a small part of that reduction will be restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs, that is, a model that projected changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors. As we explained in the August 1, 2001 final rule (66 FR 39911), beginning in FY 2003 an adjustment for regular exceptions is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Since payments are no longer being made under the regular exceptions policy in FY 2003, we are no longer using the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the August 1, 2001 final rule (66 FR 40099).

In accordance with section 1886(d)(9)(A) of the Act, under the prospective payment system for acute care hospital inpatient operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, as a result of section 4406 of Public Law 105–33, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate.

Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals under the prospective payment system for acute care hospital inpatient capital-related costs. Accordingly, for capital-related costs, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital.

A. Determination of Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

In the final rule published in the **Federal Register** on August 1, 2001 (66 FR 39947), we established a Federal rate of $390.74 for FY 2002. As a result of the changes to the factors used to establish the Federal rate that are explained in this addendum, the FY 2003 Federal rate is $407.01.

In the discussion that follows, we explain the factors that were used to determine the FY 2003 Federal rate. In particular, we explain why the FY 2003 Federal rate has increased 4.2 percent compared to the FY 2002 Federal rate. We also estimate aggregate capital payments will increase by 5.81 percent during this same period. This increase is primarily due to the increase in the number of hospital admissions and the increase in case-mix. This increase in capital payments is slightly more than last year (4.27 percent) mostly due to the restoration of the 2.1 percent reduction to the capital Federal rate (see section VI.D. of the preamble of this final rule).

Total payments to hospitals under the prospective payment system are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1 percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. Aggregate payments under the capital prospective payment system are estimated to increase in FY 2003 compared to FY 2002.

1. Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and other factors. The update framework consists of a CIPI and several policy adjustment factors.

Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The proposed rule reflected an update factor for FY 2003 under that framework of 1.1 percent, based on data available at that time. Under the update framework, the final update factor for FY 2003 is 1.1 percent. This update factor is based on a projected 0.7 percent increase in the CIPI, a 1.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a −0.3 percent adjustment for the FY 2001 DRG reclassification and recalibration, and a forecast error correction of −0.3 percent. We explain the basis for the FY 2003 CIPI projection in section III.C. of this Addendum. Below we describe the policy adjustments that have been applied.

The case-mix index is the measure of the average DRG weight for cases paid under the acute care hospital inpatient prospective payment system. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (''real'' case-mix change);
- Changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. In the update framework for the prospective payment system for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case-mix index. We also remove the effect on total payments of prior year changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than patient severity. (For example, we adjusted for the effects of the FY 2001 DRG reclassification and recalibration as part of our update for FY 2003.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2003, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that real case-mix increase will equal 1.0 percent in FY 2003. Therefore, the net adjustment for case-mix change in FY 2003 is 0.0 percentage points.

We estimate that FY 2001 DRG reclassification and recalibration will result in a 0.3 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are making a −0.3 percent adjustment for DRG reclassification and recalibration in the update for FY 2003 to maintain budget neutrality.

The capital update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of −0.3 percentage points was calculated for the FY 2001 update. That is, current historical data indicate that the forecasted FY 2001 CIPI used in calculating the FY 2001 update factor (0.9 percent) overstated the actual realized price increases (0.6 percent) by 0.3 percentage points. This over-prediction was due to prices from municipal bond yields declining faster than originally expected. Therefore, we are making a −0.3 percent adjustment for forecast error in the update for FY 2003.

Under the capital prospective payment system framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data as in the framework for the operating prospective payment system. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, changes in within-DRG severity, and expected modification of practice patterns to remove cost-ineffective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the revised operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

For FY 2003, we have developed a Medicare-specific intensity measure based on a 5-year average, using FY 1997 through 2001 data. In determining case-mix constant intensity, we found that observed case-mix increase was 0.3 percent in FY 1997, −0.4 percent in FY 1998, −0.3 percent in FY 1999, −0.7 in FY 2000, and −0.3 percent in FY 2001. Past studies of case-mix change by the RAND Corporation (''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G. M. Carter, J. P. Newhouse, and D. A. Relles, R–4098–HCFA/ProPAC (1991)) suggest that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.4 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment. Following that study, we consider up to 1.4 percent of observed case-mix change as real for FY 1997 through FY 2001. Since we did not find an increase in case-mix outside of the range of 1.0 to 1.4 percent, we believe that all of the observed case-mix increase for FYs 1997 through 2001 is real. Therefore, there was no need to employ the upper bound of 1.0 and 1.4 supported by the RAND study as we have done in the past since we did not find an increase in case-mix that was in excess of our estimate of real case-mix increase.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. We estimate that case-mix constant intensity increased by an average of 1.0 percent during FYs 1997 through 2001, for a cumulative increase of 5.2 percent, given estimates of real case-mix of 0.3 percent for FY 1997, −0.4 percent for FY 1998, −0.3 percent for FY 1999, −0.7 percent for FY 2000, and −0.3 percent for FY 2001. Since we estimate that intensity has increased during that period, the intensity adjustment for FY 2003 is 1.0 percent.

Above we described the basis of the components used to develop the 1.1 percent final capital update factor for FY 2003 as shown in Table 1 below.

TABLE 1.—CMS'S FY 2003 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index	0.7
Intensity:	1.0
Case-Mix Adjustment Factors:	
Projected Case-Mix Change	−1.0
Real Across DRG Change	1.0
Subtotal	0.0
Effect of FY 2001 Reclassification and Recalibration	−0.3
Forecast Error Correction	−0.3
Total Update	1.1

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and

inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related prospective payment system payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments.

In the August 1, 2001 final rule, we estimated that outlier payments for capital in FY 2002 would equal 5.76 percent of inpatient capital-related payments based on the Federal rate (66 FR 39948). Accordingly, we applied an outlier adjustment factor of 0.9424 to the Federal rate. Based on the thresholds as set forth in section II.A.4.c. of this Addendum, we estimate that outlier payments for capital will equal 5.31 percent of inpatient capital-related payments based on the Federal rate in FY 2003. Therefore, we are establishing an outlier adjustment factor of 0.9469 to the Federal rate. Thus, the projected percentage of capital outlier payments to total capital standard payments for FY 2003 is lower than the percentage for FY 2002.

The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the Federal rate. Therefore, the net change in the outlier adjustment to the Federal rate for FY 2003 is 1.0048 (0.9469/0.9424). The outlier adjustment increases the FY 2003 Federal rate by 0.48 percent compared with the FY 2002 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that aggregate payments for the fiscal year based on the Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the geographic adjustment factor (GAF) are projected to equal aggregate payments that would have been made on the basis of the Federal rate without such changes.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we apply separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier since the geographic adjustment factor for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the August 1, 2001 final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exceptions payment adjustment factor. As we explain in section III.A.4. of this Addendum, beginning in FY 2003 an adjustment for regular exceptions is no longer necessary. Therefore, we are no longer using the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions adjustment factor for special exception payments.

To determine the factors for FY 2003, we compared (separately for the national rate and the Puerto Rico rate) estimated aggregate Federal rate payments based on the FY 2002 DRG relative weights and the FY 2002 GAF to estimated aggregate Federal rate payments based on the FY 2003 relative weights and the FY 2003 GAF. For FY 2002, the budget neutrality adjustment factors were 0.9927 for the national rate and 0.9916 for the Puerto Rico rate (see the August 1, 2001 final rule (66 FR 40101)). In making the comparison, we set the regular and special exceptions reduction factors to 1.00.

To achieve budget neutrality for the changes in the national GAF, based on calculations using updated data, we are applying an incremental budget neutrality adjustment of 0.9991 for FY 2003 to the previous cumulative FY 2002 adjustment of (0.9927), yielding a cumulative adjustment of 0.9918 through FY 2003. For the Puerto Rico GAF, we are applying an incremental budget neutrality adjustment of 1.0081 for FY 2003 to the previous cumulative FY 2002 adjustment (0.9916), yielding a cumulative adjustment of 0.9997 through FY 2003.

We then compared estimated aggregate Federal rate payments based on the FY 2002 DRG relative weights and the FY 2002 GAF to estimated aggregate Federal rate payments based on the FY 2003 DRG relative weights and the FY 2003 GAF. The incremental adjustment for DRG classifications and changes in relative weights is 0.9966 both nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the GAF through FY 2003 are 0.9885 nationally and 0.9963 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National			Cumulative	Puerto Rico			Cumulative
	Incremental adjustment				Incremental adjustment			
	Geographic adjustment factor	DRG Reclassifications and recalibration	Combined		Geographic adjustment factor	DRG Reclassifications and recalibration	Combined	
1992	.....	.....	.....	1.00000	.....	.....	.....	.....
1993	.....	.....	0.99800	0.99800	.....	.....	.....	.....
1994	.....	.....	1.00531	1.00330	.....	.....	.....	.....
1995	.....	.....	0.99980	1.00310	.....	.....	.....	.....
1996	.....	.....	0.99940	1.00250	.....	.....	.....	.....
1997	.....	.....	0.99873	1.00123	.....	.....	.....	.....
1998	.....	.....	0.99892	1.00015	.....	.....	.....	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001 [1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001 [2]	[3] 0.99771	[3] 1.00009	[3] 0.99780	0.99922	[3] 1.00365	[3] 1.00009	[3] 1.00374	1.00508
2002	[4] 0.99666	[4] 0.99668	[4] 0.99335	0.99268	[4] 0.98991	[4] 0.99668	[4] 0.99662	0.99164
2003	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628

[1] Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2] Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3] Incremental factors are applied to FY 2000 cumulative factors.
[4] Incremental factors are applied to the cumulative factors for the first half of FY 2001.

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor for FY 2003 is similar to that used in establishing budget neutrality adjustments under the prospective payment system for operating

costs. One difference is that, under the operating prospective payment system, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital prospective payment system, there is a single DRG/GAF budget neutrality adjustment factor (the national rate and the Puerto Rico rate are determined separately) for changes in the GAF (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients, indirect medical education payments, or the large urban add-on payments.

For FY 2002, we calculated a GAF/DRG budget neutrality factor of 0.9934. In the proposed rule, we proposed a GAF/DRG budget neutrality factor of 1.0024. For this final rule, based on updated data, we are establishing a GAF/DRG budget neutrality factor of 0.9957 for FY 2003. The GAF/DRG budget neutrality factors are built permanently into the rates; that is, they are applied cumulatively in determining the Federal rate. This follows from the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The incremental change in the adjustment from FY 2002 to FY 2003 is 0.9957. The cumulative change in the rate due to this adjustment is 0.9885 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, FY 1999, FY 2000, FY 2001, FY 2002, and FY 2003: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9985 \times 0.9979 \times 0.9934 \times 0.9957 = 0.9885$).

This factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2003 geographic reclassification decisions made by the MGCRB compared to FY 2002 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital prospective payment system payments. In estimating the proportion of regular exceptions payments to total capital prospective payment system payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the August 1, 2001 final rule (66 FR 40099)) to determine the exception adjustment factor, which was applied to both the Federal and hospital-specific rates.

An adjustment for regular exceptions is no longer necessary in determining the FY 2003 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the August 1, 2001 final rule (66 FR 39949), in FY 2003 and subsequent fiscal years, no payments will be made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the special exceptions adjustment used in establishing the FY 2003 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exception payments if it meet (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

As we explained in the August 1, 2001 final rule (66 FR 39912–39914), in order to determine the estimated proportion of special exceptions payments to total capital payments, we attempted to identify the universe of eligible hospitals that may potentially qualify for special exception payments. First, we identified hospitals that met the eligibility requirements at § 412.348(g)(1). Then we determined each hospital's average fixed asset age in the earliest available cost report starting in FY 1992 and subsequent fiscal years. For each of those hospitals, we calculated the average fixed asset age by dividing the accumulated depreciation by the current year's depreciation. In accordance with § 412.348(g)(3), a hospital must have an average age of buildings and fixed assets above the 75th percentile of all hospitals in the first year of the capital prospective payment system. In the September 1, 1994 final rule (59 FR 45385), we stated that, based on the June 1994 update of the cost report files in HCRIS, the 75th percentile for buildings and fixed assets for FY 1992 was 16.4 years. However, we noted that we would make a final determination of that value on the basis of more complete cost report information at a later date. In the August 29, 1997 final rule (62 FR 46012), based on the December 1996 update of HCRIS and the removal of outliers, we finalized the 75th percentile for buildings and fixed assets for FY 1992 as 15.4 years. Thus, we eliminated any hospitals from the potential universe of hospitals that may qualify for special exception payments if its average age of fixed assets did not exceed 15.4 years.

For the hospitals remaining in the potential universe, we estimated project-size by using the fixed capital acquisitions shown on Worksheet A7 from the following HCRIS cost reports updated through June 2002.

PPS year	Cost reporting periods beginning in . . .
IX	FY 1992
X	FY 1993
XI	FY 1994
XII	FY 1995
XIII	FY 1996
XIV	FY 1997
XV	FY 1998
XVI	FY 1999
XVII	FY 2000

Because the project phase-in may overlap 2 cost reporting years, we added together the fixed acquisitions from sequential pairs of cost reports to determine project size. Under § 412.348(g)(5), the hospital's project cost must be at least $200 million or 100 percent of its operating cost during the first 12-month cost reporting period beginning on or after October 1, 1991. We calculated the operating costs from the earliest available cost report starting in FY 1992 and later by subtracting inpatient capital costs from inpatient costs (for all payers). We did not subtract the direct medical education costs as those costs are not available on every update of the HCRIS minimum data set. If the hospital met the project size requirement, we assumed that it also met the project need requirements at § 412.348(g)(2) and the excess capacity test for urban hospitals at § 412.348(g)(4).

Because we estimate that so few hospitals will qualify for special exceptions, projecting costs, payments, and margins would result in high statistical variance. Consequently, we decided to model the effects of special exceptions using historical data based on hospitals' actual cost experiences. If we determined that a hospital may qualify for special exceptions, we modeled special exceptions payments from the project start date through the last available cost report (FY 1999). (Although some FY 2000 cost reports are available in HCRIS, only a few hospitals have submitted FY 2000 costs. Consequently, too few cost reports are available to reliably model FY 2000 special exceptions payments.) For purposes of modeling we used the cost and payment data on the cost reports from HCRIS assuming that special exceptions would begin at the start of the qualifying project. In other words, when modeling costs and payment data, we ignored any regular exception payments that these hospitals may otherwise have received as if there had not been regular exceptions during the transition period. In projecting an eligible hospital's special exception payment, we applied the 70-percent minimum payment level, the cumulative comparison of current year capital prospective payment system payments and costs, and the cumulative operating margin offset (excluding 75 percent of operating DSH payments).

Our modeling of special exception payments for FY 2003 produced the following results:

Cost report	Number of hospitals eligible for special exceptions	Special exceptions as a fraction of capital payments to all hospitals
PPS IX	—	—
PPS X	—	—
PPS XI	2	—
PPS XII	5	0.0001
PPS XIII	7	0.0001
PPS XIV	14	0.0002
PPS XV	18	0.0009
PPS XVI	27	0.0018
PPS XVII	N/A	N/A

We note that hospitals still have two more cost reporting periods (PPS XVII and PPS XVIII) to complete their projects in order to be eligible for special exceptions, and, therefore, we estimate that about 20 additional hospitals could qualify for special exceptions. Thus, we project that special exception payments as a fraction of capital payments to all hospitals to be approximately 0.0030.

Because special exceptions are budget neutral, in the May 9, 2002 proposed rule (67 FR 31516), we proposed to offset the Federal capital rate by 0.40 percent for special exceptions for FY 2003. Therefore, we proposed the exceptions adjustment factor for special exception payments to equal 0.9960 (1–0.0040) to account for special exception payments in FY 2003. For this final rule, based on updated data, we are offsetting the Federal capital rate by a factor of 0.9970 (1–0.0030) to account for special exceptions payments in FY 2003.

For FY 2002, we estimated that total (regular and special) exceptions payments would equal 0.71 percent of aggregate payments based on the Federal rate. Therefore, we applied an exceptions reduction factor of 0.9929 (1–0.0071) in determining the Federal rate. As we stated, we estimate that exceptions payments for FY 2003 will equal 0.30 percent of aggregate payments based on the Federal rate. Therefore, we are applying an exceptions payment reduction factor of 0.9970 (1–0.0030) to the Federal rate for FY 2003. The exceptions adjustment factor for FY 2003 is 0.41 percent higher than the factor for FY 2002 published in the August 1, 2001 final rule. This increase is primarily due to the expiration of the regular exceptions provision and the narrowly defined nature of the special exceptions policy.

The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. Therefore, the net change in the exceptions adjustment to the FY 2003 Federal rate is 0.9970/0.9929, or 1.0041.

5. Special Adjustment to Restore the 2.1 Percent Reduction to the Standard Federal Capital Prospective Payment System Payment Rate

As we explained in section VI.D. of the preamble of this final rule, section 1886(g)(1)(A) of the Act, as amended by section 4402 of Public Law 105–33, requires the Secretary to reduce the unadjusted standard Federal capital prospective payment system payment rate by 2.1 percent for discharges on or after October 1, 1997, and through September 30, 2002. Therefore, under the statute the additional 2.1 percent reduction no longer applies to discharges occurring after September 30, 2002. Accordingly, we are revising § 412.308(b) to restore the 2.1 percent reduction to the unadjusted standard Federal capital prospective payment system payment rate for discharges occurring on or after October 1, 2002 to the level that it would have been without the reduction.

As we state in section VI.D. of the preamble of this final rule and in the August 29, 1997 final rule (62 FR 46012), we applied a factor of 0.8222 in FY 1998 to account for both the reduction equal to the FY 1995 budget neutrality factor (0.1568) and the 2.1 percent reduction (0.021) provided for under section 4402 of Public Law 105–33. In order to determine the adjustment factor needed to restore the 2.1 percent reduction, we divide the amount of the adjustment without the 2.1 percent reduction (1–0.1568 = 0.8432) by the amount of the adjustment with the 2.1 percent reduction (0.8222). Therefore, we are applying a factor of 1.02554 (0.8432/0.8222) to the unadjusted FY 2002 standard Federal capital prospective payment system payment rate to restore the 2.1 percent reduction for discharges occurring on or after October 1, 2002.

6. Standard Capital Federal Rate for FY 2003

For FY 2002, the capital Federal rate was $390.74. In this final rule, we are establishing a capital Federal rate of $407.01 for FY 2003. The Federal rate for FY 2003 was calculated as follows:

- The FY 2003 update factor is 1.0110; that is, the update is 1.10 percent.
- The FY 2003 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 0.9957.
- The FY 2003 outlier adjustment factor is 0.9469.
- The FY 2003 (special) exceptions payments adjustment factor is 0.9970.
- The special adjustment factor for FY 2003 to restore the 2.1 percent reduction to the standard Federal rate is 1.0255.

Since the Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we have made no additional adjustments in the standard Federal rate for these factors, other than the budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the factors and adjustments for FY 2003 affected the computation of the FY 2003 Federal rate in comparison to the FY 2002 Federal rate. The FY 2003 update factor has the effect of increasing the Federal rate by 1.10 percent compared to the FY 2002 Federal rate, while the geographic and DRG budget neutrality factor has the effect of decreasing the Federal rate by 0.43 percent. The FY 2003 outlier adjustment factor has the effect of increasing the Federal rate by 0.48 percent compared to the FY 2002 Federal rate. The FY 2003 exceptions reduction factor has the effect of increasing the Federal rate by 0.41 percent compared to the exceptions reduction for FY 2002. The special adjustment factor for FY 2003 to restore the 2.1 percent reduction to the standard Federal rate has the effect of increasing the Federal rate by 2.55 percent compared to the FY 2002 Federal rate. The combined effect of all the changes is to increase the Federal rate by 4.16 percent compared to the FY 2002 Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2002 FEDERAL RATE AND FY 2003 FEDERAL RATE

	FY 2002	FY 2003	Change	Percent change
Update factor [1]	1.0130	1.0110	1.0110	1.10
GAF/DRG Adjustment Factor [1]	0.9934	0.9957	0.9957	−0.43
Outlier Adjustment Factor [2]	0.9424	0.9469	1.0048	0.48
Exceptions Adjustment Factor [2]	0.9929	0.9970	1.0041	0.41
Special Adjustment [3]	N/A	1.0255	1.0255	2.55
Federal Rate	$390.74	$407.01	1.0416	4.16

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the rates. Thus, for example, the incremental change from FY 2002 to FY 2003 resulting from the application of the 0.9957 GAF/DRG budget neutrality factor for FY 2003 is 0.9957.

[2] The outlier reduction factor and the exceptions reduction factor are not built permanently into the rates; that is, these factors are not applied cumulatively in determining the rates. Thus, for example, the net change resulting from the application of the FY 2003 outlier reduction factor is 0.9469/0.9424, or 1.0048.

[3] Section 1886(g)(1)(A) of the Act requires, for discharges on or after October 1, 1997, and through September 30, 2002, the Secretary to reduce the unadjusted standard Federal capital prospective payment system payment rate by 2.1 percent. Thus, the 2.1 percent reduction no longer applies to discharges occurring after September 30, 2002, and we are proposing to restore the 2.1 percent reduction by applying a factor of 1.0255 (see section VI.D. of the preamble of this final rule).

We are also providing a chart that shows how the final FY 2003 capital Federal rate differs from the proposed FY 2003 capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2003 PROPOSED FEDERAL RATE AND FY 2003 FINAL FEDERAL RATE

	Proposed FY 2003	Final FY 2003	Change	Percent change
Update factor	1.0110	1.0110	1.0000	0.00
GAF/DRG Adjustment Factor	1.0024	0.9957	0.9933	−0.67
Outlier Adjustment Factor	0.9460	0.9469	1.0010	0.10
Exceptions Adjustment Factor	0.9960	0.9970	1.0010	0.10
Special Adjustment	1.0255	1.0255	1.0000	0.00
Federal Rate	$408.90	407.01	0.9954	−0.46

7. Special Rate for Puerto Rico Hospitals

As explained at the beginning of section II.D. of this Addendum, hospitals in Puerto Rico are paid based on 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. The Puerto Rico rate is derived from the costs of Puerto Rico hospitals only, while the Federal rate is derived from the costs of all acute care hospitals participating in the prospective payment system (including Puerto Rico). To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended rate. The GAF is calculated using the operating prospective payment system wage index and varies, depending on the MSA or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated in section III.A.4. of this Addendum, for Puerto Rico the proposed GAF budget neutrality factor was 1.0080, while the proposed DRG adjustment was 1.0034, for a proposed combined cumulative adjustment of 1.0115. For this final rule, based on updated data, the FY 2003 GAF budget neutrality factor is 1.0081, while the DRG adjustment is 0.9966, for a combined cumulative adjustment for Puerto Rico of 1.0047.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the rate (50 percent) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the rate (50 percent) is multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico rate as a result of Public Law 105–33.

For FY 2002, before application of the GAF, the special rate for Puerto Rico hospitals was $187.73. With the changes we proposed to the factors used to determine the rate, the proposed FY 2003 special rate for Puerto Rico was $199.70. For this final rule, based on the final factors, the FY 2003 capital rate for Puerto Rico is $198.29.

B. Calculation of Inpatient Capital-Related Prospective Payments for FY 2003

With the end of the capital prospective payment system transition period in FY 2001, all hospitals (except ''new'' hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the Federal rate in FY 2003. The applicable Federal rate was determined by making adjustments as follows:

- For outliers, by dividing the standard Federal rate by the outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2003, the standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The outlier thresholds for FY 2003 are in section II.A.4.c. of this Addendum. For FY 2003, a case qualifies as a cost outlier if the cost for the case plus the IME and DSH payments is greater than the prospective payment rate for the DRG plus $33,560.

An eligible hospital may also qualify for a special exception payment under § 412.348(g) for up through the 10th year beyond the end of the capital transition period if it meets: (1) A project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test as described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include sole community hospitals, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment level. This amount is offset by: (1) Any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital prospective payment system; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. Under § 412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals.

During the transition period, new hospitals (as defined under § 412.300) were exempt from the capital prospective payment system for their first 2 years of operation and are paid 85 percent of their reasonable costs during that period. Effective with the third year of operation through the remainder of the transition period, under § 412.324(b) we paid the hospital under the appropriate transition methodology. If the hold-harmless methodology was applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period. As discussed in section VI.B. of the preamble of this final rule, under § 412.304(c)(2), we will pay a new hospital 85 percent of their reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the Federal rate. Effective with

the third year of operation through the remainder of the transition period, we will pay the hospital based on 100 percent of the capital Federal (that is, the same methodology used to pay all other hospitals subject to capital prospective payment system).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. The CIPI was last rebased to FY 1992 in the August 30, 1996 final rule (61 FR 46196). In this final rule, we are revising and rebasing the CIPI to a FY 1997 base year to reflect the more recent structure of capital costs. For further details on the rebasing and revision of the CIPI, see section IV.B. of this final rule.

2. Forecast of the CIPI for Federal Fiscal Year 2003

We are forecasting the CIPI to increase 0.7 percent for FY 2003. This reflects a projected 1.3 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.0 percent increase in other capital expense prices in FY 2003, partially offset by a 2.3 percent decline in vintage-weighted interest rates in FY 2003. The weighted average of these three factors produces the 0.7 percent increase for the CIPI as a whole.

IV. Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

The inpatient operating costs of hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in regulations at § 413.40. Under these limits, a hospital-specific target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors).

Under existing § 413.40(c)(4)(iii)(B), for cost reporting periods beginning and during FYs 1998 and through 2002, in the case of a psychiatric hospital or hospital unit, a rehabilitation hospital or hospital unit, or a long-term care hospital, the target amount may not exceed the updated figure for the 75th percentile of target amounts adjusted to take into account the differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospitals for hospitals and hospital units in the same class (psychiatric, rehabilitation, and long-term care) for cost reporting periods ending during FY 1996. The target amount is multiplied by the number of Medicare discharges in a hospital's cost reporting period, yielding the ceiling on aggregate Medicare inpatient operating costs for the cost reporting period.

Each hospital-specific target amount is adjusted annually, at the beginning of each hospital's cost reporting period, by an applicable update factor. Under existing §§ 413.40(c)(4)(ii) and (d)(1)(i) and (ii), effective for cost reporting periods beginning during FY 2003, payments to existing excluded hospitals and hospital units will no longer be subject to a 75th percentile cap. These excluded hospitals and hospital units will be paid based on their aggregate Medicare inpatient operating costs, which may not exceed their ceiling. The ceiling on a hospital's or hospital unit's aggregate Medicare inpatient operating costs would be computed using the hospital's or hospital unit's target amount from the previous cost reporting period updated using the rate-of-increase percentage specified in § 413.40(c)(3)(viii) and multiplied by the total number of Medicare discharges.

Section 1886(b)(3)(B) of the Act, as implemented in regulations at § 413.40(c)(3)(viii), provides that, for cost reporting periods beginning on or after October 1, 2002, the update factor for a hospital or hospital unit is the percentage increase projected by the hospital market basket index. The most recent projected forecast of the market basket percentage increase for FY 2003 for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment system is 3.5 percent. This percentage change is estimated by CMS' Office of the Actuary and reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital care. Therefore, we are providing that the update to a hospital's target amount for its cost reporting period beginning in FY 2003 is 3.5 percent.

As discussed in section VII. of the preamble of this final rule, we are making an adjustment to the updated cap on the target amounts per discharge for each class of new excluded hospitals and hospital units for cost reporting periods beginning during FY 2003, using the prospective payment system wage index without taking into account the reclassifications under sections 1886(d)(8)(B) and (d)(10) of the Act. For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to prospective payment system reclassifications, and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Regulations at § 413.40(f)(2)(ii) specify the payment methodology for new hospitals and hospital units, effective October 1, 1997.

For cost reporting periods beginning in FY 2003, in the May 9, 2002 proposed rule, we included the following proposed caps:

Class of excluded hospital or unit	FY 2003 proposed labor-related share	FY 2003 proposed nonlabor-related share
Psychiatric	$ 7,047	$2,801
Long-Term Care	17,269	6,866

In this final rule, using updated data, we have recalculated the proposed caps for cost reporting periods beginning in FY 2003. The final FY 2002 caps are listed below:

Class of excluded hospital or unit	FY 2003 labor-related share	FY 2003 nonlabor-related share
Psychiatric	$7,054	$2,804
Long-Term Care	17,286	6,872

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new rehabilitation hospitals and units since they will be paid under the inpatient rehabilitation facility prospective payment system.

Regulations at § 413.40(d) specify the formulas for determining bonus and relief payments for excluded hospitals and specify established criteria for an additional bonus payment for continuous improvement.

V. Tables

This section contains the tables referred to throughout the preamble to this final rule and in this Addendum. For purposes of this final rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1A, 1C, 1D, 2, 3A, 3B, 4A, 4B, 4C, 4F, 4G, 4H, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 7A, 7B, 8A, 8B, 9, and 10 are presented below. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor
Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D—Capital Standard Federal Payment Rate
Table 2—Hospital Average Hourly Wage for Federal Fiscal Years 2001 (1997 Wage Data), 2002 (1998 Wage Data), and 2003 (1999 Wage Data) Wage Indexes and 3–Year Average of Hospital Average Hourly Wages
Table 3A—3–Year Average Hourly Wage for Urban Areas
Table 3B—3–Year Average Hourly Wage for Rural Areas
Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas
Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas
Table 4C—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified
Table 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF)
Table 4G—Pre-Reclassified Wage Index for Urban Areas
Table 4H—Pre-Reclassified Wage Index for Rural Areas
Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric and Arithmetic Mean Length of Stay
Table 6A—New Diagnosis Codes
Table 6B—New Procedure Codes
Table 6C—Invalid Diagnosis Codes
Table 6D—Invalid Procedure Codes
Table 6E—Revised Diagnosis Code Titles
Table 6F—Revised Procedure Code Titles
Table 6G—Additions to the CC Exclusions List
Table 6H—Deletions to the CC Exclusions List
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2001 MedPAR Update March 2002 GROUPER V19.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2001 MedPAR Update March 2002 GROUPER V20.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) July 2002
Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) July 2002
Table 9—Hospital Reclassifications and Redesignations by Individual Hospital—FY 2003
Table 10—Mean and Standard Deviations by Diagnosis-Related Groups (DRGs)—FY 2003

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,022.60	$1,228.60	$2,974.75	$1,209.15

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large urban area		Other Areas	
	Labor	Nonlabor	Labor	Nonlabor
National	$2,996.76	$1,218.10	$2,996.76	$1,218.10
Puerto Rico	1,464.13	589.35	1,440.95	580.02

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$407.01
Puerto Rico	$198.29

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
010001	16.4088	17.4467	17.9841	17.2930
010004	17.9732	19.0010	20.1613	19.0027
010005	17.5985	18.6554	19.9733	18.7567
010006	16.7480	17.6115	18.3931	17.6130
010007	15.4798	15.6788	16.0781	15.7477
010008	14.7443	17.4728	19.0182	17.0908
010009	18.7731	18.4979	19.7272	18.9866
010010	16.4468	16.4664	17.7348	16.9045
010011	20.7972	22.4292	24.8922	22.5886
010012	17.7171	15.8686	20.3376	17.8002
010015	15.4510	19.1178	19.8205	18.1040
010016	17.2473	20.2198	20.3175	19.2142
010018	17.6449	18.9388	19.5519	18.7214
010019	16.3493	17.0856	17.6414	17.0165
010021	16.2919	15.1241	25.3335	17.8534
010022	18.5879	17.6435	22.1250	19.2162
010023	16.1025	16.3209	18.4567	16.9929
010024	16.2900	15.9034	17.3746	16.5229
010025	15.1356	15.1548	17.4702	15.9257
010027	11.7900	16.8595	16.5157	14.5941
010029	17.6461	18.3605	19.3393	18.4481
010031	18.7835	18.6402	19.2612	18.9043
010032	12.5995	15.3590	16.3967	14.8530
010033	20.3923	21.2986	21.9828	21.2187
010034	15.0959	15.3639	14.9379	15.1325
010035	20.1853	15.9439	20.7808	18.7551
010036	17.8140	17.7166	18.7158	18.0757
010038	18.2671	19.6098	19.6887	19.2225
010039	20.1045	20.3406	21.3550	20.6323
010040	18.9376	20.0983	20.4486	19.7782
010043	30.7489	18.6640	17.3567	20.8449
010044	22.0091	24.0265	23.4575	23.1128
010045	15.2200	17.0417	18.7569	16.8822
010046	17.3970	18.9737	18.8741	18.4218
010047	13.3521	15.4190	13.4130	14.0833
010049	14.7590	15.5246	16.3349	15.5762
010050	18.5163	17.9830	20.3028	18.9035
010051	11.9275	11.8108	12.3280	12.0151
010052	16.5486	18.0653	19.8289	18.3581
010053	14.6267	15.5649	15.4156	15.2353
010054	18.5103	19.4955	20.9656	19.7134
010055	18.9526	18.8590	19.5667	19.1301
010056	19.2175	19.6577	20.5645	19.7867
010058	16.1702	16.9715	16.1265	16.4288
010059	19.1286	18.8020	19.1270	19.0199
010061	14.9547	14.5003	18.5320	15.9823
010062	14.7732	12.3259	16.9721	14.6098
010064	20.4139	19.5256	20.5650	20.1572
010065	16.4049	16.8752	17.0557	16.7998
010066	15.4317	13.1559	14.8904	14.4355
010068	12.0525	18.6925	23.4322	17.0157
010069	13.8636	14.7211	15.4497	14.6885
010072	14.9526	16.2339	16.5652	15.9117
010073	13.8601	14.1273	13.5594	13.8482
010078	17.9202	18.1363	18.5127	18.1930
010079	16.4421	17.0648	17.1612	16.8948
010081	18.9474	17.2996 *	18.1637	
010083	16.8933	18.0312	18.4282	17.8382
010084	18.4965	18.7769	19.8773	19.0316
010085	18.4744	19.9023	21.5860	19.9817
010086	16.6694	16.5711	16.8886	16.7103
010087	19.0033	18.0567	18.7915	18.6490
010089	16.8042	17.7800	19.5241	18.0099
010090	18.3866	18.9445	19.5635	18.9671
010091	13.9405	17.0799	17.1775	15.9756
010092	16.9900	17.8144	18.5478	17.8124

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
010095	12.4525	12.2597	12.3064	12.3323
010097	13.0413	12.7286	14.2675	13.3206
010098	15.9165	14.0300	15.5763	15.1201
010099	15.9874	15.5619	15.9232	15.8146
010100	17.2011	17.9430	18.3755	17.8826
010101	15.3859	14.4625	18.9525	16.0723
010102	13.7933	13.8136	15.7777	14.4205
010103	17.9358	17.7242	22.0802	19.0882
010104	17.7126	16.8457	21.9457	18.6228
010108	17.9017	19.4617	19.1596	18.8606
010109	15.3107	14.6752	15.9627	15.2873
010110	15.6317	15.8283	15.5817	15.6824
010112	15.1401	16.8271	15.6041	15.8270
010113	16.9683	16.8936	18.2774	17.3728
010114	15.2454	17.0760	19.3772	17.2041
010115	14.6268	14.2261	15.3510	14.7053
010118	18.8477	17.0834	17.4620	17.7157
010119	18.8024	19.3942	19.5163	19.3327
010120	17.2336	18.2567	18.9975	18.1726
010121	14.6444	14.5262	15.2345	14.7784
010123	16.7344	19.2140	*	17.9083
010124	16.2846	16.7465	*	16.5122
010125	15.5304	16.0136	16.5117	16.0174
010126	19.5710	19.1065	19.5933	19.4288
010127	19.5190	18.2786	*	18.9233
010128	14.5056	14.4322	16.6899	15.2189
010129	14.7286	16.1733	16.7609	15.8741
010130	16.6809	19.5573	17.4614	17.7942
010131	17.8260	20.1883	19.0492	18.9966
010134	18.8835	19.9856	18.5179	19.1797
010137	12.1217	20.5828	21.3573	17.6481
010138	12.8675	14.5254	14.1369	13.8739
010139	19.0001	20.4331	20.5708	19.9541
010143	16.7911	17.6212	18.9084	17.7778
010144	17.1320	18.2040	18.8272	18.0453
010145	20.8434	20.5895	20.8157	20.7476
010146	18.5198	19.1415	18.3666	18.6687
010148	12.2214	15.8349	18.4591	15.1664
010149	18.6333	18.0156	19.0199	18.5806
010150	17.8951	18.9359	19.4819	18.7907
010152	17.8306	18.7677	19.8990	18.8539
010155	9.0300	15.0689	13.6136	11.6435
010157	*	*	17.7372	17.7373
010158	17.3227	18.3957	18.6052	18.1306
010159	*	*	19.3950	19.3950
020001	28.1747	28.0394	28.6530	28.2947
020002	24.5815	25.1987	28.2759	25.9928
020004	30.5667	25.4679	29.2351	28.4867
020005	30.2920	29.2378	35.0860	31.4575
020006	31.2404	28.1417	33.0843	30.7594
020007	27.8319	32.3852	27.7269	28.9902
020008	29.4146	30.8691	31.8878	30.7354
020009	20.1930	18.4660	18.5594	19.0476
020010	23.6727	22.7559	23.7275	23.3859
020011	30.4727	28.0658	27.5062	28.6155
020012	24.8543	25.5320	26.7586	25.6982
020013	23.8847	28.1557	29.5646	26.9336
020014	27.3823	24.5875	27.7870	26.6146
020017	26.8319	28.0572	28.8752	27.9519
020024	24.0872	25.3205	25.5933	25.0276
020025	21.7557	20.2583	29.4375	23.2312
030001	20.3673	21.7869	22.8996	21.6709
030002	21.5977	21.8375	23.1450	22.2070
030003	23.4833	22.6804	23.9849	23.3723
030004	14.0711	15.5478	13.8452	14.3965
030006	18.2668	20.0273	20.5019	19.5831

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
030007	19.6708	21.5169	22.2473	21.1843
030008	22.2758	22.2190	*	22.2524
030009	18.1794	18.7557	19.1258	18.6629
030010	19.0907	19.5123	19.8496	19.4665
030011	19.2973	19.4310	19.8141	19.5088
030012	18.9918	20.6585	21.1099	20.2847
030013	20.7458	20.0535	19.9517	20.2223
030014	19.9315	19.7966	20.3017	20.0154
030016	19.3967	19.4785	22.2526	20.4395
030017	22.8765	21.7938	23.1702	22.6064
030018	20.2032	20.8980	21.8067	20.9825
030019	21.7005	21.2540	22.0341	21.6682
030022	19.2966	19.5794	22.3351	20.3379
030023	23.6697	24.1678	25.4626	24.5066
030024	22.2541	23.6009	23.7663	23.2450
030025	12.7254	11.9894	20.2690	14.6291
030027	15.7554	17.6555	18.5500	17.3221
030030	20.8303	21.6932	23.1280	21.8856
030033	20.0044	20.2820	20.3034	20.1983
030034	16.8241	20.8689	19.5578	19.0205
030035	19.2781	20.0226	20.5339	19.9127
030036	20.7567	21.6371	22.2690	21.5890
030037	22.8266	23.7615	23.7325	23.4266
030038	22.6776	22.9822	23.4477	23.0337
030040	18.5456	19.7636	19.3706	19.2127
030041	15.8921	18.8717	18.4750	17.5529
030043	20.9341	20.5598	20.5653	20.6716
030044	16.8649	17.6575	18.6781	17.7554
030047	22.6401	21.4412	22.7385	22.2630
030049	19.0881	19.3580	19.7315	19.3525
030054	15.3338	15.0657	15.7973	15.4130
030055	16.3613	20.2991	20.8373	19.1429
030059	24.0465	22.6279	27.3929	24.5505
030060	19.2461	18.6313	19.5021	19.1145
030061	18.9063	19.9047	21.1013	19.9959
030062	17.6738	18.7172	19.2670	18.6035
030064	19.5673	20.3837	21.6435	20.5204
030065	20.5130	20.7838	22.2846	21.2496
030067	14.4446	17.2778	17.6414	16.3935
030068	17.3614	17.7208	18.9718	18.0528
030069	19.0961	21.0936	23.4902	21.1503
030080	20.5144	20.6581	21.2299	20.8174
030083	23.3355	23.5229	23.5049	23.4608
030085	21.0954	20.8690	21.6542	21.2320
030086	19.5436	*	*	19.5436
030087	21.4084	21.9465	23.1339	22.1276
030088	19.8682	20.5340	21.4491	20.6552
030089	20.4019	20.9516	22.0850	21.2122
030092	20.6986	21.8308	19.6625	20.5481
030093	19.7262	20.4314	21.7195	20.6797
030094	21.6218	22.8123	21.8049	22.0984
030095	13.7293	13.7664	20.5222	15.2252
030099	16.1541	18.2263	19.8092	18.2768
030100	*	23.7609	23.5868	23.6643
030101	*	19.2547	21.1029	20.2450
030102	*	18.2413	21.5405	19.8425
030103	*	*	28.9308	28.9308
030104	*	*	32.8668	32.8669
040001	15.1624	16.9178	16.3882	16.1463
040002	13.0592	15.1107	16.1353	14.6990
040003	14.2089	15.5740	15.5186	15.0890
040004	17.8476	17.9034	19.0105	18.2433
040005	13.2597	11.1318	16.5465	13.4890
040007	21.9583	18.6998	22.5319	20.8769
040008	15.3040	14.7985	20.2121	16.6104
040010	18.6023	19.4913	19.8251	19.3459

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
040011	14.5319	16.0995	17.1337	15.8295
040014	17.6340	18.1434	19.3996	18.3693
040015	16.5891	15.5207	17.9602	16.7200
040016	19.0295	20.2321	19.8087	19.7068
040017	13.5098	15.4736	16.5648	15.1885
040018	17.6027	18.7463	18.8203	18.3807
040019	22.6769	23.4163	21.0465	22.2688
040020	16.4827	18.9844	17.6056	17.6157
040021	17.6398	19.6835	21.3321	19.4636
040022	17.0397	20.8281	19.2393	18.9742
040024	14.4541	17.6607	17.1507	16.4393
040025	11.5079	13.4705	14.8071	13.1413
040026	19.5563	19.7924	21.0143	20.1201
040027	16.0975	17.4431	17.7161	17.1113
040028	14.6584	13.9946	15.2850	14.6612
040029	17.8787	21.1370	22.5094	20.5216
040030	13.5428	11.2402	16.5488	13.3388
040032	13.7030	13.2872	13.8013	13.5932
040035	12.8300	10.9569	11.0611	11.5521
040036	18.9757	20.2012	21.1066	20.1370
040037	14.6559	14.0941	15.4984	14.7015
040039	14.3576	14.7177	15.2811	14.8024
040040	18.0895	19.1984	19.6704	18.9937
040041	15.9896	16.4624	17.7783	16.7177
040042	15.2142	15.2057	16.6875	15.6976
040044	12.6275	13.3501	17.1869	14.3743
040045	14.9429	16.2469	16.6648	15.9379
040047	16.8654	17.5336	18.6295	17.6726
040050	13.3818	14.0036	14.2087	13.8730
040051	15.8627	16.6039	18.2152	16.8577
040053	16.3610	15.0219	14.1508	15.1659
040054	15.3219	14.2577	16.5217	15.3669
040055	17.1269	18.0414	17.4236	17.5299
040058	17.6766	16.4278	19.3124	17.6534
040060	12.8148	17.9805	15.4220	15.0376
040062	18.2048	17.8902	19.4255	18.5267
040064	10.7255	11.5029	13.3479	11.7813
040066	18.3377	19.7144	19.5619	19.1774
040067	14.6014	14.4741	15.0081	14.6924
040069	17.5052	17.0026	18.9754	17.8560
040070	16.9027	16.9700	18.6066	17.5468
040071	16.9610	17.6144	18.4956	17.6590
040072	16.0895	17.4960	21.3320	18.2060
040074	18.3224	18.7542	20.8465	19.2921
040075	13.3623	14.0975	14.6681	14.0257
040076	19.0732	20.5840	21.8010	20.4612
040077	12.9211	13.9114	14.7230	13.8164
040078	18.7600	18.5821	19.6363	18.9943
040080	19.2461	19.3707	22.8153	20.3838
040081	11.3169	11.1332	12.4796	11.6373
040082	16.2152	15.1331	16.4840	15.9329
040084	17.2613	17.7295	18.3410	17.7584
040085	16.8957	16.5216	14.1782	15.7843
040088	17.9636	17.1624	18.3159	17.8055
040090	17.8282	19.0824	16.6619	17.8476
040091	19.8700	20.1378	20.2904	20.1018
040093	12.3537	13.9741	14.7132	13.5635
040100	14.7587	15.6833	17.0271	15.9393
040105	15.3319	14.3896	14.8936	14.8814
040106	15.6545	18.1341	19.0936	17.8001
040107	18.8120	17.8628	20.6852	19.1446
040109	14.6266	16.6278	16.2496	15.8538
040114	18.8743	21.1231	21.3826	20.4184
040116	20.2716	*	*	20.2716
040118	19.3720	18.2123	19.6248	19.0444
040119	15.5338	16.9407	18.6028	17.0376

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
040124	19.1349	19.2889	*	19.2100
040126	12.5368	11.6517	16.3391	13.4177
040132	17.5179	10.3875	24.6941	15.4438
040134	18.0787	19.0185	22.1291	19.8434
040135	22.6761	23.0084	*	22.8797
040136	*	*	21.4139	21.4138
050002	37.8295	36.9630	30.2629	34.5243
050006	19.5594	18.2061	22.4890	20.0298
050007	30.7126	30.8676	31.6270	31.0595
050008	26.2458	26.3682	28.2021	26.8667
050009	26.8159	28.4734	28.3021	27.8816
050013	23.2201	28.0569	27.2552	25.9477
050014	22.8478	23.6745	25.1664	23.9039
050015	26.2481	27.7731	28.2204	27.4404
050016	20.5566	21.2045	22.7014	21.5040
050017	23.9625	25.6178	25.7403	25.1023
050018	15.4721	15.2903	16.5909	15.8441
050021	25.8966	*	*	25.8966
050022	24.0318	24.5254	26.2574	24.9836
050024	21.3989	22.4274	21.5230	21.7688
050025	23.3896	24.8245	26.0161	24.7262
050026	27.8736	23.1904	23.4651	24.6800
050028	16.4671	17.6138	17.9421	17.3234
050029	25.1259	24.6839	26.6783	25.4673
050030	20.9812	21.5621	21.8639	21.4881
050032	25.2010	24.3598	24.4176	24.6502
050033	24.9328	32.0179	31.1768	29.1633
050036	21.2420	21.8239	24.8017	22.6740
050038	28.6528	29.9698	32.1757	30.1303
050039	22.7117	22.8288	23.8478	23.1402
050040	32.1287	30.2607	30.1153	30.8697
050042	24.8067	24.5260	25.4903	24.9502
050043	32.9958	33.8255	38.8988	35.0749
050045	19.8831	21.1474	21.0356	20.7131
050046	25.3185	25.2005	25.3067	25.2745
050047	29.9255	29.9580	31.6959	30.5375
050051	17.8945	18.7809	17.9266	18.1624
050054	20.7212	22.0982	19.2395	20.6257
050055	29.3984	29.2730	32.0923	30.2190
050056	27.4321	23.8396	24.7994	25.2478
050057	21.1554	20.7420	22.2584	21.3963
050058	23.1641	23.3009	24.8366	23.7800
050060	20.7747	20.5450	21.9971	21.2660
050061	23.5454	24.5488	23.9906	24.0316
050063	24.8851	25.7593	25.5798	25.3924
050065	24.0420	24.6290	27.6677	25.3130
050066	16.5725	16.1649	26.3920	18.5257
050067	23.1966	25.8857	22.1250	23.5170
050068	20.6851	19.3615	19.2325	19.8460
050069	25.9420	24.6153	25.8560	25.4593
050070	32.5166	34.0721	36.4136	34.4086
050071	33.1850	34.4367	36.4834	34.7318
050072	33.2858	39.7321	36.1146	36.2550
050073	33.3922	32.8555	36.1054	34.1118
050075	33.9095	33.7160	37.8104	35.1272
050076	27.7797	33.9752	37.0415	32.6495
050077	24.1019	24.1404	25.3481	24.5518
050078	23.0736	24.3150	23.0613	23.4423
050079	33.2432	30.0167	36.5455	33.0896
050082	22.1009	23.7617	23.7718	23.2042
050084	23.5866	25.4517	25.1155	24.6796
050088	20.8406	24.9641	25.2282	23.4877
050089	20.9117	22.8450	23.4120	22.3589
050090	23.4097	24.6070	25.4545	24.4799
050091	25.2792	23.7713	26.6463	25.1713
050092	16.7969	17.1211	17.1883	17.0299

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
050093	25.2130	25.6647	27.2048	26.0447
050095	33.6718	30.4847	29.2226	31.0314
050096	20.0487	22.7394	22.5034	21.6293
050097	16.7054	22.5991	24.2548	20.5747
050099	24.8091	25.3722	26.2363	25.4947
050100	29.8758	25.2031	23.9877	26.2195
050101	31.0264	31.8957	33.1232	32.0303
050102	22.2937	24.0014	22.6741	22.9916
050103	24.7932	25.4133	23.5946	24.5653
050104	25.5797	26.9726	27.3260	26.6171
050107	21.2690	22.2019	22.2746	21.9397
050108	23.5564	25.1758	25.6983	24.8127
050110	20.1870	19.9589	21.3399	20.4921
050111	21.5487	20.7897	21.0813	21.1480
050112	25.3015	26.8182	29.1268	27.0733
050113	28.8420	28.5224	32.4493	30.0540
050114	24.7286	26.6757	27.6486	26.3583
050115	21.3291	23.0182	24.3748	22.9340
050116	25.2130	24.9196	27.0331	25.6442
050117	23.3612	22.2123	23.0697	22.8657
050118	23.7698	23.7129	24.9094	24.1342
050121	19.5252	18.7272	18.8430	19.0230
050122	26.3172	26.9546	26.9048	26.7269
050124	22.7736	24.5069	23.9379	23.7017
050125	29.6147	32.0230	33.3290	31.6254
050126	23.9247	24.6752	26.9718	25.2082
050127	22.1937	20.9027	20.5928	21.0815
050128	25.7240	26.6132	26.2519	26.1998
050129	26.5030	24.0108	23.7432	24.6166
050131	31.0732	32.5462	33.0980	32.2202
050132	24.0834	24.0173	24.1583	24.0881
050133	24.9746	23.2093	23.9479	23.9946
050135	23.2361	24.7157	23.2750	23.7026
050136	24.7921	24.7280	28.0754	25.7753
050137	32.6507	32.9192	33.7489	33.1070
050138	37.3286	38.1584	40.8912	38.7884
050139	32.9351	31.4984	35.1492	33.0424
050140	34.1499	32.7609	36.7096	34.4570
050144	27.8751	27.4069	29.8983	28.3985
050145	32.3857	34.5185	37.5003	34.7881
050148	21.9211	20.0971	21.1622	21.0247
050149	24.6078	26.8674	25.8880	25.7652
050150	24.9073	24.6596	25.9494	25.1761
050152	34.0766	33.3305	34.5096	33.9668
050153	30.5714	32.3389	33.3333	32.1183
050155	21.0257	25.3354	23.2118	23.0854
050158	27.5623	28.6071	28.9764	28.3557
050159	23.2912	22.5313	26.6139	23.7086
050167	21.9128	21.8796	21.9596	21.9174
050168	23.3511	25.1937	27.1971	25.2088
050169	22.3888	24.8407	24.7737	23.9439
050170	23.9574	24.3654	27.7693	25.2103
050172	20.1841	19.6120	22.0400	20.6111
050173	24.5545	24.8694	*	24.7049
050174	30.2140	30.2775	31.6888	30.7398
050175	27.2806	24.7548	26.0146	25.8419
050177	21.7943	21.1396	22.5039	21.8034
050179	21.7175	23.8868	22.8941	22.7755
050180	31.8947	33.3257	34.0900	33.1860
050183	20.3638	*	*	20.3638
050186	22.4155	23.6288	25.0791	23.7560
050188	28.0918	28.2364	30.6007	29.0015
050189	22.8687	27.4071	28.3295	26.4046
050191	20.8321	25.3516	29.4162	25.1452
050192	18.6701	14.1996	19.0400	17.0362
050193	22.6316	24.9444	25.5294	24.3542

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
050194	29.7371	29.5678	28.5389	29.2648
050195	35.5621	36.9068	39.1617	37.2637
050196	18.5180	18.2411	19.4304	18.7370
050197	35.7449	32.4030	34.6878	34.1675
050204	23.6105	22.7099	23.0192	23.1063
050205	23.6831	24.1691	24.1275	23.9917
050207	21.6214	22.9941	23.7774	22.8095
050211	31.6084	31.7280	33.2481	32.1766
050213	21.4806	21.4951	*	21.4880
050214	21.7335	24.0276	21.1480	22.2422
050215	29.8563	35.0459	31.6895	32.1029
050217	19.6010	20.2042	21.3026	20.3986
050219	21.7444	21.2458	21.7637	21.5978
050222	27.4809	23.3563	23.0670	24.3640
050224	23.5316	23.5101	24.8431	23.9839
050225	23.3480	21.6820	22.0981	22.3835
050226	27.7315	24.4443	26.1959	26.0496
050228	34.0711	34.2596	36.0632	34.7751
050230	27.7357	26.6291	26.7963	27.0820
050231	26.1508	26.7321	27.4697	26.8010
050232	24.3072	24.5245	25.8640	24.8981
050234	25.7035	24.6126	25.0104	25.0823
050235	25.2527	27.0922	26.0323	26.1239
050236	26.9803	25.9458	27.7406	26.8805
050238	24.2922	24.5823	25.1796	24.6748
050239	22.6625	23.2711	24.9469	23.6287
050240	26.3657	26.7620	28.8910	27.3259
050241	26.3740	29.8345	*	27.9992
050242	31.1576	32.0829	33.5646	32.2627
050243	28.9635	26.4627	26.0256	27.1221
050245	23.8124	23.2716	24.6092	23.8921
050248	26.2015	27.6457	28.4413	27.4692
050251	21.6574	23.6360	27.9531	24.2057
050253	16.0701	16.7540	21.0399	17.6028
050254	19.3126	20.1176	22.3414	20.6227
050256	23.6887	23.4835	25.1104	24.1533
050257	15.2306	17.2596	15.6379	16.0441
050260	23.2421	27.4234	30.1623	26.5840
050261	20.0552	20.1040	19.4649	19.8596
050262	28.8785	29.5550	30.8866	29.7520
050264	32.1312	36.0331	33.2270	33.7253
050267	26.2264	26.0401	27.8393	26.6370
050270	24.0439	25.3757	26.4092	25.2781
050272	22.4247	23.0587	23.3443	22.9405
050274	20.0422	*	*	20.0422
050276	29.8624	33.3302	34.0633	32.3736
050277	20.0520	26.0822	23.6065	23.0165
050278	24.7787	23.9289	24.9699	24.5628
050279	20.8444	21.8949	22.2776	21.6332
050280	25.2149	25.6651	26.3392	25.7541
050281	19.6888	24.2251	25.2699	22.9927
050282	28.8261	25.4428	26.4698	26.9213
050283	29.7734	31.7669	32.3270	31.3481
050286	16.5708	19.4241	20.6191	18.4349
050289	34.1393	30.4750	32.2125	32.1522
050290	28.6231	29.6796	31.5000	29.9312
050291	30.2748	29.4029	30.9334	30.2109
050292	21.6243	20.8410	21.4357	21.2903
050293	22.2963	24.1875	17.1935	20.7533
050295	21.2892	21.7883	25.4405	22.8697
050296	27.2948	28.3906	30.0984	28.6215
050298	24.4477	23.2006	22.4000	23.3022
050299	26.4543	25.5035	24.6751	25.5099
050300	23.5116	25.9228	26.0298	25.2222
050301	22.5201	21.1403	24.7987	22.7770
050305	34.5185	36.7908	36.6981	36.0318

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
050307	17.2147	*	*	17.2147
050308	29.3803	28.9284	30.3887	29.5604
050309	23.7884	25.3515	25.5221	24.8819
050312	26.7617	26.0015	26.0172	26.2525
050313	21.7577	25.6827	28.9126	25.5297
050315	24.7086	22.7359	22.5906	23.3600
050317	21.6937	*	*	21.6937
050320	30.4101	32.4809	31.6571	31.4911
050324	26.6049	25.3694	26.8313	26.2820
050325	24.4862	23.6327	22.6353	23.5919
050327	23.9484	25.6450	31.1527	26.6180
050329	19.7455	21.6984	24.2134	21.8073
050331	22.2536	25.0230	25.2110	24.0855
050333	19.4589	19.1449	14.1808	17.2305
050334	34.2330	34.2557	34.3956	34.2968
050335	23.0258	22.9926	22.9335	22.9822
050336	20.7979	21.3402	22.0203	21.3892
050342	20.1841	20.8255	22.4510	21.1447
050343	17.2085	*	*	17.2084
050348	23.8779	25.1085	29.3364	26.0263
050349	14.9754	15.0667	15.4536	15.1663
050350	24.8340	26.4161	27.2368	26.1456
050351	25.4791	24.8121	25.2436	25.1768
050352	26.1380	26.4262	27.7489	26.7934
050353	23.0564	23.2699	24.1009	23.4992
050355	17.2778	21.0969	41.4710	21.8695
050357	22.6545	24.5345	24.3540	23.9188
050359	17.7907	21.7548	19.7653	19.6431
050360	31.3526	31.7583	33.3592	32.1693
050366	23.7528	19.6823	22.0442	21.7233
050367	28.2805	30.7328	31.7487	30.2799
050369	27.0548	26.2234	26.6627	26.6233
050373	26.9776	27.8275	29.9749	28.1900
050376	26.5840	28.0990	28.4026	27.6603
050377	17.1764	17.0012	11.6463	16.0071
050378	25.9810	26.9101	27.8389	26.9067
050379	15.2022	18.4278	24.2408	18.3635
050380	31.4343	31.9578	31.5962	31.6646
050382	26.1398	25.9244	26.3968	26.1598
050385	24.6083	*	27.1692	25.6464
050388	19.1512	22.0122	17.6762	19.5684
050390	25.0426	24.2700	25.8556	25.0345
050391	18.9266	20.0615	19.0832	19.3414
050392	21.6729	22.9430	24.9003	23.1073
050393	25.6964	24.1981	25.4028	25.0965
050394	23.0604	23.1526	23.1641	23.1275
050396	24.0636	25.3729	25.7580	25.0612
050397	20.2601	20.6397	23.3212	21.1533
050401	20.7473	18.4593	*	19.5658
050404	17.3396	15.9839	16.4845	16.6030
050406	17.3016	17.8596	21.5282	18.7226
050407	29.9642	30.8346	32.0753	30.9310
050410	17.6769	19.8508	17.1718	18.1805
050411	34.8899	33.1943	33.1718	33.7076
050414	24.2060	25.9723	24.5471	24.8993
050417	21.5739	23.3005	23.3862	22.7800
050419	23.7584	23.4936	25.1449	24.1188
050420	22.3166	23.5438	26.4201	24.1207
050423	17.3771	21.3552	24.8113	20.9574
050424	22.8350	24.0727	25.9378	24.3139
050425	32.8364	35.3712	33.7276	33.9997
050426	25.2453	29.0120	26.7941	26.9305
050427	20.1674	16.4330	31.4154	22.4396
050430	23.8788	21.2275	25.2322	23.4217
050432	24.4133	24.5630	26.0686	25.0170
050433	17.4643	18.9021	17.7980	18.0325

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
050434	19.7591	*	24.0017	21.7788
050435	25.6676	23.3426	22.5428	23.8194
050436	14.8121	*	*	14.8121
050438	25.0138	23.2583	25.3763	24.5467
050440	23.5167	22.5400	25.4767	23.8254
050441	28.9804	31.8774	33.4696	31.2892
050443	19.9020	17.2875	16.8897	17.9266
050444	21.4533	22.4530	22.6469	22.1781
050446	20.4908	22.3422	20.3611	21.0344
050447	17.9751	18.9851	24.4339	20.7186
050448	19.7046	21.7718	22.6612	21.3755
050449	23.8001	23.4614	*	23.6286
050454	28.7432	30.0792	30.3063	29.7856
050455	20.1643	19.8577	20.5575	20.1952
050456	20.1254	18.1585	17.5846	18.4965
050457	34.4949	32.1910	34.2116	33.6080
050464	25.3292	25.7710	25.8092	25.6421
050468	23.3050	22.2926	22.9771	22.8607
050469	23.8759	24.5205	*	24.1896
050470	16.0292	16.0805	15.7765	15.9567
050471	25.6172	27.1597	29.4705	27.3360
050476	22.4754	24.0253	25.9458	24.2592
050477	27.9595	27.5819	30.8781	28.6932
050478	24.5401	26.3306	28.1829	26.3141
050481	28.9722	27.7973	28.5320	28.4396
050482	18.1217	16.0114	21.6091	18.2297
050483	22.7182	*	*	22.7182
050485	24.1983	24.6906	25.2723	24.7165
050488	34.6939	31.7481	33.8291	33.4344
050491	26.8703	27.4600	27.7412	27.3548
050492	19.5457	20.5030	23.4977	21.2468
050494	29.2621	29.1296	30.2875	29.5621
050496	32.5168	34.9704	32.7474	33.3456
050497	13.8110	15.4115	*	14.5264
050498	24.9677	26.1716	27.6099	26.2387
050502	22.3788	25.3701	27.2724	24.9510
050503	24.4069	23.3745	25.7668	24.5458
050506	25.0845	25.0333	27.1555	25.7636
050510	33.3774	33.7481	36.2548	34.4910
050512	35.3581	34.4368	36.0785	35.2923
050515	35.3419	33.7321	37.3440	35.4231
050516	24.7992	26.1969	25.3450	25.4513
050517	20.9550	22.0985	23.6067	22.1150
050522	35.3784	36.2127	37.0295	36.1638
050523	27.0544	31.2522	32.1272	30.1439
050526	23.8099	26.4014	26.8814	25.6479
050528	19.0611	18.9155	21.1741	19.7510
050531	22.7308	21.3948	*	22.0804
050534	24.0700	24.0001	24.4038	24.1576
050535	25.4215	26.8511	27.7626	26.6201
050537	22.2256	24.0354	26.2342	24.2063
050539	20.7129	23.3846	23.7778	22.7078
050541	34.4573	36.6149	37.0551	36.1147
050542	16.0892	17.7737	21.8129	18.4625
050543	22.3994	21.6795	22.4134	22.1708
050545	26.3304	31.7280	33.6302	29.6054
050546	26.1949	38.8087	39.4266	31.5013
050547	26.8305	37.7681	37.7633	31.6990
050548	28.8083	29.8516	30.3336	29.5564
050549	27.2765	28.9615	30.0948	28.8364
050550	24.8048	25.6588	26.5515	25.6491
050551	25.4652	24.8084	26.1042	25.4556
050552	21.5216	20.3239	20.6068	20.8970
050557	21.1243	22.2562	23.8340	22.4197
050559	23.5759	24.7866	26.3799	24.8811
050561	34.5791	33.4423	34.2065	34.0632

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
050564	23.5922	24.2091	*	23.9025
050565	23.7829	20.8349	*	22.1110
050566	17.4423	22.3448	21.7712	20.6000
050567	24.6454	25.0787	26.2588	25.3566
050568	19.5816	20.5376	21.9313	20.7038
050569	26.5479	27.3429	27.3294	27.0680
050570	25.2294	25.8619	26.8965	26.0357
050571	26.2039	24.0154	26.2226	25.4641
050573	24.9644	25.6589	25.9380	25.5333
050575	19.5611	20.7090	27.8579	22.3375
050577	25.1549	23.5487	25.2861	24.6231
050578	28.5379	28.9009	32.0554	29.7756
050579	30.4952	29.9348	32.0245	30.8151
050580	25.9004	24.6962	22.7522	24.4365
050581	23.8584	24.9807	26.0580	24.9311
050583	24.3987	25.8800	26.2664	25.5050
050584	21.2366	19.5805	24.5294	21.6929
050585	25.9426	24.2824	26.4446	25.5528
050586	23.4079	23.1850	*	23.3000
050588	25.3094	24.5472	27.0506	25.7065
050589	24.8698	23.8880	23.7918	24.1317
050590	22.4480	24.4797	25.1100	23.9970
050591	23.9412	25.0209	26.7662	25.1993
050592	21.1745	22.1174	23.8267	22.4222
050594	27.1584	27.7002	28.7415	27.8366
050597	22.8523	23.3280	23.1209	23.0979
050598	24.3597	23.9202	25.1622	24.5206
050599	29.1221	26.0892	26.3782	27.1542
050601	31.8670	29.7417	29.7734	30.4482
050603	23.3390	21.7031	24.9032	23.2638
050604	34.0461	35.4034	36.4669	35.3805
050608	18.0947	18.1664	20.9171	18.9982
050609	34.9935	33.5028	34.8949	34.4263
050613	23.3835	30.2413	34.9768	28.8604
050615	23.8815	27.5682	25.8698	25.6901
050616	22.7437	24.9843	25.0016	24.2299
050618	21.6509	21.4895	22.3548	21.8584
050623	29.1806	27.5832	28.6475	28.4545
050624	22.7148	26.4659	22.4030	23.6850
050625	26.4849	27.5816	29.3665	27.8711
050630	23.9159	24.2120	25.2915	24.5153
050633	23.1918	25.4283	27.8165	25.4720
050636	21.2618	23.5257	25.0214	23.2191
050638	18.2859	18.2159	15.6375	17.1599
050641	21.8315	17.1258	17.9379	18.6266
050644	22.3456	22.1489	*	22.2474
050661	19.6780	*	*	19.6781
050662	26.9606	35.0989	38.9592	31.5421
050663	30.6591	24.9110	22.7770	25.2271
050667	24.9979	27.5045	26.9236	26.1684
050668	42.0974	61.7751	57.8627	51.0207
050670	20.0152	24.6101	24.1626	22.6855
050674	34.7380	32.4807	33.7845	33.5929
050675	15.6794	*	*	15.6794
050676	18.6672	20.2087	16.3948	18.3663
050677	35.6503	33.6070	34.0936	34.4139
050678	26.8741	22.7756	25.2143	24.8560
050680	28.0584	31.4839	31.9166	30.4823
050682	26.2882	17.3566	19.8107	20.5443
050684	22.3398	23.3697	24.2792	23.3071
050685	31.1725	35.1307	30.4194	32.1391
050686	35.2631	33.4420	34.8278	34.4753
050688	30.6635	31.0648	34.9936	32.8691
050689	30.7295	30.9399	34.0571	31.9763
050690	32.8204	34.8112	36.7516	34.8707
050693	26.8265	25.5662	29.1213	27.1699

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
050694	23.2293	23.5572	25.1964	23.9614
050695	21.1377	24.4301	26.2838	24.0169
050696	28.0015	28.3291	29.6685	28.6563
050697	21.1566	18.2338	24.1116	21.0055
050698	*	*	24.9559	24.9559
050699	25.7843	17.5296	23.4611	21.9391
050701	22.6959	24.3055	26.4901	24.3588
050704	22.8716	22.7618	25.6565	23.8031
050707	26.2732	27.8958	28.2637	27.6356
050708	22.7821	24.8647	24.5606	24.0910
050709	21.9598	19.4977	21.8770	21.0737
050710	26.9060	27.5828	30.5918	28.4895
050713	17.7259	16.8538	18.2822	17.6031
050714	28.9314	30.1925	30.3290	29.7818
050717	25.9534	28.7973	31.5021	28.6924
050718	17.6062	18.0940	22.5989	19.6750
050719	25.5508	23.0833	*	23.8495
050720	*	25.8677	*	25.8677
050723	*	*	32.0291	32.0291
060001	21.3659	21.1819	21.4562	21.3343
060003	19.8023	20.4682	21.9043	20.7102
060004	22.8750	21.4496	22.9265	22.4496
060006	19.3651	20.0213	21.0003	20.1579
060007	17.4682	18.2977	19.3071	18.3452
060008	18.0333	18.4590	18.7097	18.3997
060009	21.4312	22.7164	23.9272	22.7121
060010	24.0872	23.6827	24.2735	24.0195
060011	23.4366	22.3458	22.2058	22.6927
060012	20.1442	19.4932	21.2980	20.3114
060013	22.7346	19.1256	23.5248	21.7755
060014	24.2459	24.3210	25.7701	24.7918
060015	20.9773	23.2469	23.6015	22.5801
060016	16.4707	20.2408	20.2361	18.8056
060018	20.3183	21.5083	21.8478	21.1863
060020	18.3099	18.8985	19.7348	18.9920
060022	21.0558	21.0830	22.8059	21.6916
060023	19.2373	21.5475	22.4731	21.0953
060024	21.9955	22.9185	24.3658	23.1396
060027	20.9846	22.0713	22.1717	21.7670
060028	23.2065	23.1792	24.2985	23.5665
060029	20.8585	18.2938	19.8498	19.6763
060030	20.5002	20.3452	21.2612	20.7131
060031	21.1649	22.5067	23.3995	22.3074
060032	23.4162	22.8123	24.7678	23.6728
060033	15.9085	16.0760	17.8514	16.5805
060034	22.4791	23.2816	24.3652	23.3995
060036	15.0698	18.5988	18.6521	17.3368
060037	15.5611	15.4513	15.7495	15.5902
060038	14.0791	14.3249	16.6525	15.2260
060041	14.8934	19.1263	19.5872	17.5256
060042	19.1892	20.8597	19.3967	19.6496
060043	13.6717	13.4443	15.4073	14.1048
060044	19.7039	20.8673	21.3102	20.6215
060046	19.4567	22.2699	22.6819	21.4974
060047	15.8770	17.1534	17.9173	16.9143
060049	21.7797	23.0613	25.9592	23.6523
060050	18.2238	19.0832	*	18.6522
060052	13.4210	14.8729	16.0543	14.6462
060053	15.9806	18.0232	19.4746	17.7396
060054	22.8985	20.4160	19.7753	20.9273
060056	18.2831	18.1263	21.9586	19.5606
060057	26.4046	25.4185	24.6599	25.4808
060058	15.4856	13.8539	16.4504	15.2822
060060	15.6469	15.6018	19.4418	16.7387
060062	17.2991	16.8640	17.1032	17.1033
060064	21.2207	22.7797	28.8746	24.1014

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
060065	21.6305	24.5572	24.4554	23.5808
060066	16.3485	17.2537	17.5556	16.9855
060070	17.3184	18.8960	19.2220	18.4993
060071	17.5987	17.4068	17.6452	17.5489
060073	15.7860	17.0846	18.4971	17.0767
060075	24.1550	23.8724	25.0552	24.3665
060076	24.8732	20.3265	22.9426	22.6703
060085	13.6277	14.3409	10.9724	12.8943
060088	25.2786	13.7174	20.7211	18.6295
060090	22.2974	16.3760	16.5321	18.2600
060096	21.9623	20.8937	21.9951	21.6204
060100	23.5986	23.9305	24.8116	24.1151
060103	24.8151	23.5083	24.4962	24.2301
060104	22.2295	21.1820	24.4248	22.5603
060107	14.2698	21.9221	*	16.3130
060108	*	*	19.1327	19.1327
060109	*	*	27.3180	27.3180
070001	26.0878	26.3596	27.7441	26.7515
070002	26.2801	26.1768	26.6881	26.3761
070003	25.6949	27.5200	28.1721	27.1059
070004	22.4871	24.2567	25.4310	24.0188
070005	26.6483	26.9151	27.6733	27.0706
070006	27.5674	28.6413	33.6291	30.1330
070007	26.9505	26.3313	28.0875	27.1381
070008	23.0227	24.2971	25.1362	24.0979
070009	24.6201	24.1871	24.9408	24.5838
070010	26.2354	29.2194	28.3168	27.8716
070011	23.3638	23.0883	24.8206	23.7802
070012	23.0321	28.8067	37.5917	28.5860
070015	23.8240	28.1204	29.2693	27.0233
070016	24.9148	24.4633	28.4833	25.9349
070017	26.2923	26.0424	27.5515	26.5441
070018	28.0689	30.6864	32.6301	30.4394
070019	25.7283	24.9249	26.2348	25.6326
070020	23.9987	25.9964	26.6203	25.5573
070021	25.2978	26.3043	29.4596	26.9916
070022	26.5691	26.9111	27.2423	26.9019
070024	25.2983	24.8948	26.3544	25.5382
070025	25.1315	25.4345	27.3592	25.9673
070027	23.6412	26.8450	25.9279	25.4322
070028	24.6788	25.7492	26.7286	25.7052
070029	22.0080	23.9682	23.8427	23.2454
070030	28.9117	22.1578	*	25.8929
070031	23.4419	24.1198	25.6347	24.3735
070033	30.4214	31.4736	34.1591	31.9816
070034	28.9200	29.4916	30.0744	29.4693
070035	23.0869	24.1423	24.5996	23.9254
070036	28.8400	29.9470	31.2961	29.9831
070038	*	*	26.3126	26.3126
070039	22.9032	22.3356	*	22.7640
080001	25.4836	24.8833	26.8887	25.7287
080002	19.6011	20.1965	20.9385	20.3062
080003	22.1856	23.1275	24.8200	23.2380
080004	21.9391	22.9706	21.7344	22.1849
080006	20.0792	22.6671	20.9399	21.1768
080007	19.6213	21.3746	21.5415	20.9038
090001	21.7526	21.5751	23.0365	22.1027
090002	19.4191	21.5726	20.6550	20.5048
090003	22.1090	23.1268	27.1087	23.8330
090004	24.3367	25.5054	25.9717	25.2072
090005	23.8620	26.3074	26.8690	25.6346
090006	20.8675	22.0957	22.9658	21.9607
090007	22.1973	29.2840	24.6668	25.6566
090008	20.2166	25.2708	*	22.7566
090010	24.1287	23.6616	25.9373	24.5182
090011	27.4781	26.6349	27.6038	27.2394

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
100001	19.5796	20.2157	22.0101	20.5122
100002	20.7136	21.0222	21.5772	21.1199
100004	14.6283	15.4149	16.1638	15.4361
100006	20.1133	21.2293	21.6922	21.0708
100007	21.7242	22.1590	22.5317	22.1527
100008	20.4980	20.8381	21.6416	21.0118
100009	22.6419	22.1741	22.6370	22.4873
100010	21.9078	23.0637	23.9582	22.9492
100012	19.6177	20.4659	22.0244	20.7239
100014	19.8023	19.5770	21.9875	20.4440
100015	18.4779	18.0654	18.9383	18.4860
100017	19.0608	19.8655	20.1417	19.7084
100018	21.0332	21.6388	22.6587	21.7978
100019	22.6152	23.5462	25.8297	24.0395
100020	21.3848	20.7816	21.7421	21.3134
100022	26.4094	26.5695	27.4235	26.7855
100023	19.9739	19.1787	20.2034	19.7906
100024	21.8791	22.1332	22.9872	22.3458
100025	18.7774	19.4529	20.1360	19.4381
100026	20.5641	20.9461	21.3742	20.9788
100027	19.1481	14.7916	20.5889	17.6926
100028	19.3757	19.3371	20.3751	19.7063
100029	20.8745	20.8950	22.2553	21.3244
100030	22.8204	20.5952	19.5604	20.7196
100032	19.8127	19.7451	20.6543	20.0503
100034	17.8743	19.5282	20.0099	19.0752
100035	20.1540	23.8117	21.3519	21.7961
100038	23.3578	24.5864	24.9548	24.3305
100039	21.5297	21.7861	23.3111	22.2259
100040	19.0449	18.6321	19.5154	19.0650
100043	18.7993	18.8206	20.7688	19.4486
100044	21.4764	22.7236	22.9474	22.4012
100045	20.9216	21.0228	22.8096	21.6136
100046	21.6207	21.3028	23.2027	22.0159
100047	20.0114	20.6068	21.4971	20.7134
100048	15.0584	15.7790	17.3663	16.1388
100049	18.8535	19.1025	20.9490	19.6376
100050	17.2377	17.9039	17.8960	17.6845
100051	23.1273	17.9453	19.3258	19.7301
100052	17.9537	18.1780	19.6620	18.5844
100053	20.1724	19.6800	21.6634	20.4905
100054	23.5491	21.1518	20.9612	21.8945
100055	18.0547	18.8760	19.1324	18.6804
100056	25.7863	21.8506	23.1737	23.6729
100057	19.9712	19.5319	22.3406	20.5479
100060	23.2561	23.5997	*	23.4313
100061	22.1133	22.9176	24.5277	23.1393
100062	19.4370	21.4424	21.9054	21.0072
100063	19.2629	18.4642	19.2510	19.0090
100067	18.0877	18.4851	19.2168	18.5203
100068	19.9305	19.8308	19.9648	19.9094
100069	16.8271	17.3666	18.5789	17.6344
100070	18.7408	20.0381	20.9592	19.7991
100071	17.5451	17.7234	20.7461	18.6293
100072	21.0225	20.5968	22.0317	21.2423
100073	21.1898	22.2812	22.2425	21.9197
100075	18.3688	19.4480	20.4604	19.4085
100076	17.8733	17.8612	18.4815	18.0825
100077	22.3438	19.0640	20.9482	20.7726
100078	18.4499	19.2891	16.6003	18.0834
100080	22.1966	22.7153	22.9720	22.6367
100081	14.8313	15.4253	16.5149	15.5681
100082	18.8998	*	*	18.8998
100084	22.3674	22.7009	24.5682	23.2945
100085	22.1231	*	*	22.1231
100086	21.6997	23.3718	24.3067	23.1462

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
100087	23.6090	23.6562	22.1764	23.1720
100088	20.3693	20.5566	20.6667	20.5318
100090	19.1479	19.7695	21.0431	20.0438
100092	17.9216	20.1760	21.4601	19.8695
100093	16.5128	16.8422	18.7153	17.3704
100098	19.2427	20.8315	21.1723	20.4066
100099	15.7823	15.7591	16.5271	16.0129
100102	18.9701	19.7673	19.0193	19.2459
100103	17.2364	18.7844	19.1222	18.3910
100105	21.6604	21.8268	22.7793	22.1049
100106	17.2527	17.4958	21.4342	18.9189
100107	20.1281	20.0719	21.7553	20.6632
100108	19.9593	20.1125	18.4127	19.5107
100109	20.8440	20.8370	20.6007	20.7572
100110	20.8995	20.1853	22.8127	21.3407
100112	25.2570	15.2128	16.2109	17.7240
100113	23.2020	21.3489	23.3380	22.5455
100114	21.6262	22.8178	22.5326	22.3196
100117	20.7624	20.6962	21.3085	20.9272
100118	22.8702	20.7323	21.7067	21.7370
100121	*	18.5842	19.9033	19.2306
100122	19.8783	19.2643	24.9765	21.2147
100124	17.0713	20.4022	20.0867	19.1730
100125	18.9535	19.6097	20.3232	19.6414
100126	19.5413	19.3103	21.4349	20.0428
100127	19.9860	19.2122	20.5153	19.9091
100128	20.1536	22.8826	23.5835	22.0798
100129	19.1936	*	*	19.1936
100130	18.6751	20.0947	21.0023	19.9341
100131	23.4373	23.1622	24.6184	23.7719
100132	18.1167	18.7863	19.5259	18.7919
100134	15.1764	15.9733	16.9302	15.9832
100135	18.8253	19.1865	19.7675	19.2758
100137	18.6955	19.5562	20.9015	19.8112
100138	17.1373	14.9539	14.9760	15.5324
100139	15.6514	15.2532	15.7378	15.5541
100140	17.1389	19.0584	20.2288	18.8297
100142	19.6815	18.4113	17.7250	18.5714
100144	12.2877	*	*	12.2877
100146	18.1267	21.3359	20.8381	20.1028
100147	14.6616	15.2348	17.1566	15.6835
100150	21.2807	21.5057	25.4269	22.5635
100151	21.6087	23.8489	26.6143	24.0945
100154	20.0015	20.4068	21.6715	20.7094
100156	19.4980	18.4779	20.0348	19.3485
100157	22.6744	22.6195	24.2188	23.1792
100159	10.2793	10.7818	15.0633	11.7916
100160	20.5581	23.3121	22.6942	22.2030
100161	22.2994	22.3053	23.3612	22.6650
100162	20.1411	20.3110	24.2950	21.5951
100165	19.0388	22.6622	*	21.0526
100166	20.0250	21.2309	22.2419	21.1141
100167	23.4075	23.2969	25.7676	24.1390
100168	20.1994	20.3167	23.0121	21.2144
100169	20.9506	20.3017	21.6397	20.9720
100170	18.5088	19.3005	21.2469	19.5894
100172	14.3446	14.8826	15.7827	14.9994
100173	18.5662	17.1337	18.3828	18.0289
100174	26.1826	21.9807	*	24.0224
100175	18.1692	20.5442	21.2532	20.0936
100176	22.8604	24.3089	24.6595	23.9677
100177	24.4296	24.4284	25.1037	24.6852
100179	22.3015	23.0849	23.9633	23.1372
100180	20.2130	21.5388	22.7781	21.4816
100181	23.0800	18.9510	17.9048	19.7877
100183	24.6121	23.0654	22.2063	23.2470

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
100187	20.2533	20.8535	21.4988	20.8818
100189	21.3147	26.5962	27.1295	24.9742
100191	19.9879	21.0647	22.0526	21.0151
100199	21.7193	*	*	21.7193
100200	22.4579	23.8729	24.8878	23.7939
100204	20.8995	20.2193	21.1922	20.7717
100206	19.5710	20.1171	20.3436	20.0192
100208	21.2117	20.7029	20.4678	20.8077
100209	22.4577	23.3903	22.8236	22.8823
100210	21.3575	21.8545	23.0431	22.0260
100211	20.6427	20.7516	21.6367	21.0021
100212	21.1187	21.1263	21.7239	21.3228
100213	20.6558	21.1818	22.0176	21.2986
100217	20.5909	22.7335	22.7116	21.9737
100220	21.2796	21.8246	24.6233	22.4044
100221	17.3965	21.2321	23.2263	20.3743
100223	20.6302	20.2233	21.8962	20.9551
100224	20.0251	21.8628	22.3567	21.3927
100225	20.6802	21.5059	22.4619	21.5424
100226	20.6858	21.8808	22.7301	21.8197
100228	21.3168	20.8810	24.9691	22.4542
100229	19.6908	18.2350	19.7259	19.2271
100230	20.5051	22.5650	23.4169	22.2637
100231	17.9226	18.7526	21.5712	19.2641
100232	19.3491	19.8002	20.1459	19.7694
100234	20.9104	21.6360	24.3355	22.1730
100235	17.1622	*	*	17.1622
100236	20.3766	20.6942	21.7886	20.9395
100237	22.0865	23.2408	23.2712	22.8481
100238	19.6367	20.8252	23.3747	21.2439
100239	21.3193	19.4481	23.2242	21.2389
100240	20.4340	21.0606	21.3495	20.9700
100241	14.7224	17.1063	14.1059	15.3322
100242	17.9260	18.6938	19.1097	18.5870
100243	21.2644	20.8041	22.4495	21.5381
100244	18.6227	20.5352	21.4386	20.2806
100246	19.6376	21.9247	23.5614	21.5790
100248	20.7007	21.2988	22.1553	21.4214
100249	19.2808	18.1397	18.4932	18.6366
100252	17.7778	19.8079	22.0976	19.8858
100253	21.3232	22.4778	22.6517	22.1811
100254	19.6598	19.5523	20.4410	19.8924
100255	25.2119	21.0284	20.7228	22.1421
100256	20.9356	21.2786	22.4844	21.5612
100258	21.3501	20.0300	22.0790	21.1494
100259	20.3815	21.1160	21.4991	21.0228
100260	21.0506	24.9183	21.2413	22.2814
100262	20.0433	21.0927	22.7137	21.2022
100264	19.1556	19.9491	21.7410	20.2633
100265	18.8301	18.2291	20.2664	19.1601
100266	18.2993	19.3623	20.2821	19.3534
100267	20.1141	21.7430	22.8054	21.5751
100268	23.9249	24.0538	23.5414	23.8302
100269	21.6724	22.5114	26.0271	23.4143
100270	15.1462	16.7148	20.8217	17.5380
100271	20.4824	20.8695	21.9823	21.1576
100275	20.9188	21.4904	23.2920	21.8964
100276	22.3646	24.1022	24.8251	23.8061
100277	16.6255	19.7241	14.9157	16.6327
100279	22.9095	22.5879	23.1776	22.8857
100280	17.3676	18.1972	19.0157	18.2076
100281	22.4392	23.0142	23.4729	23.0255
100282	19.1978	18.4884	20.9256	19.5516
100284	*	18.9448	18.5716	18.7499
110001	19.1971	20.1150	22.4535	20.5583
110002	17.1406	19.5158	20.2149	18.9927

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
110003	18.1168	17.1450	18.2792	17.8514
110004	19.5591	19.7733	20.6096	19.9776
110005	17.7348	22.4568	21.8105	20.9768
110006	20.7820	21.0601	22.0325	21.3092
110007	21.9505	25.2523	25.9135	24.3734
110008	22.0081	18.5265	20.4972	20.3338
110009	16.3069	17.4306	16.6452	16.8052
110010	23.3213	23.9104	25.1930	24.1454
110011	18.6144	18.9823	20.4028	19.3209
110013	16.2811	18.9160	16.7833	17.3444
110014	16.0658	18.1787	18.4463	17.4976
110015	21.2146	20.9926	21.2600	21.1563
110016	22.5321	14.2398	14.7571	16.4041
110017	13.1960	22.2537	21.2970	19.1377
110018	19.6064	22.1480	23.0577	21.6355
110020	18.3147	19.4617	20.9687	19.5535
110023	21.1994	22.0546	21.6512	21.6299
110024	20.7297	20.7345	21.3945	20.9529
110025	19.5749	20.4232	20.2493	20.0573
110026	17.2977	16.2484	16.9161	16.8269
110027	16.0642	14.7081	19.8976	16.6619
110028	20.1547	29.1670	28.1695	25.3235
110029	20.2906	21.2150	21.3694	20.9629
110030	18.8105	19.6412	20.4656	19.6568
110031	19.9482	20.0553	20.9219	20.3082
110032	15.7349	18.2014	19.2685	17.6324
110033	22.1879	25.6335	23.1939	23.6010
110034	19.6055	19.5554	23.0724	20.6505
110035	19.3795	22.7950	21.8646	21.4160
110036	22.2498	24.9234	22.5481	23.1534
110038	17.7060	17.7396	18.4508	17.9715
110039	20.6011	20.4998	18.9817	19.9578
110040	17.0743	16.8083	17.7798	17.2164
110041	18.8035	20.2755	20.1398	19.7378
110042	24.0153	25.2331	25.0535	24.7832
110043	20.1016	20.6150	21.2714	20.6367
110044	16.3624	17.2087	17.5905	17.0642
110045	20.2498	21.3049	22.2424	21.1738
110046	19.7377	21.4905	22.8820	21.3991
110048	16.3148	15.6113	18.8751	16.8775
110049	16.1817	16.8639	17.1396	16.7155
110050	20.7619	19.2291	18.9048	19.6044
110051	17.0070	17.2292	17.2050	17.1503
110054	*	20.0549	20.7825	20.4374
110056	15.6202	17.7959	17.9037	17.2909
110059	16.6678	16.7990	17.8076	17.0958
110061	15.0367	16.3557	17.4601	16.2796
110062	18.8019	17.0053	17.9421	17.8940
110063	16.9612	18.5071	18.0256	17.8146
110064	18.9515	19.1203	18.8742	18.9828
110065	15.6771	16.3546	16.9829	16.3529
110066	21.0207	22.4189	23.4554	22.2503
110069	19.3109	20.9575	21.1513	20.4832
110070	21.0227	17.3438	19.6361	19.3058
110071	14.5984	18.8321	21.5042	17.7757
110072	12.7877	12.7625	13.6626	13.0734
110073	15.4261	16.4658	17.9372	16.5696
110074	21.3945	22.3769	24.4924	22.7969
110075	18.5199	20.1757	20.1604	19.6679
110076	21.2867	21.9798	23.6127	22.2999
110078	22.3718	24.0893	25.7416	24.0644
110079	21.0593	22.1070	22.3641	21.8325
110080	18.4768	19.1839	19.4635	19.0419
110082	23.8768	24.3140	22.7015	23.5986
110083	23.1219	23.1463	22.2609	22.8147
110086	18.2815	16.6374	19.0164	17.9653

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
110087	21.7773	22.7069	24.0994	22.9041
110089	18.5587	19.3855	19.0453	18.9917
110091	19.5114	21.5328	23.7110	21.5509
110092	17.3479	16.9725	15.9178	16.7054
110093	*	16.9827	*	16.9827
110094	14.5641	16.9503	16.8890	16.0918
110095	16.4670	17.1195	18.9904	17.5350
110096	16.8541	17.4157	18.0418	17.4444
110097	15.5811	17.4558	17.8454	16.7969
110098	16.3532	16.0597	16.7800	16.4135
110100	18.6978	19.0764	18.6822	18.8175
110101	10.8187	18.8491	13.8787	13.5799
110103	13.6842	21.1837	21.5683	17.7316
110104	15.7781	15.9431	16.6322	16.1150
110105	16.8909	16.7775	18.1306	17.2936
110107	19.3609	19.3897	21.2267	19.9924
110108	19.7938	25.2161	20.1140	21.3451
110109	15.9359	16.4031	16.5977	16.3157
110111	18.5108	18.3951	18.4274	18.4433
110112	19.0619	19.8986	18.9574	19.2821
110113	16.8179	15.9532	16.0942	16.2556
110114	14.6888	16.4812	16.8297	16.0087
110115	43.9427	22.5049	26.5759	28.7027
110118	20.5368	19.7509	17.5714	19.1118
110120	15.2589	17.7452	18.4738	17.1958
110121	16.2711	19.3643	18.8744	18.1723
110122	21.1385	21.1469	20.6070	20.9564
110124	17.5732	18.3366	19.4093	18.3953
110125	19.1311	18.0090	19.5666	18.8882
110127	14.6143	20.3765	16.1107	17.0392
110128	18.1845	18.0835	20.3046	18.8711
110129	18.9388	19.0001	20.9442	19.6354
110130	16.0580	14.6011	16.6915	15.7591
110132	16.0419	16.3943	17.1820	16.5355
110134	12.5723	19.8639	19.0305	17.6901
110135	17.4380	17.3504	15.6668	16.7018
110136	18.0639	16.9629	20.7827	18.4333
110140	17.8870	17.7915	*	17.8447
110141	13.2501	14.4935	13.2710	13.6692
110142	14.6144	13.9525	14.1203	14.2070
110143	20.1603	22.5926	22.4254	21.8082
110144	16.8685	17.5112	17.5678	17.2876
110146	16.1316	17.1835	17.8499	17.1022
110149	17.7535	32.1975	25.2525	24.0956
110150	20.2644	21.2909	22.8322	21.4768
110152	15.3996	15.1324	16.3837	15.6496
110153	19.2744	20.5068	20.6972	20.1497
110154	14.9636	17.3761	16.5286	16.2471
110155	15.5306	16.5146	16.4756	16.1555
110156	14.7477	16.3876	16.0759	15.7007
110161	21.7153	22.2861	24.5776	22.9656
110163	20.4202	18.6637	20.1183	19.7095
110164	20.2074	21.2160	22.6605	21.3867
110165	21.2577	20.8030	22.5604	21.5831
110166	20.5882	20.5049	22.3822	21.1111
110168	20.6646	21.8058	22.3181	21.6516
110169	20.6385	22.6648	23.3750	21.9474
110171	23.7893	25.5296	24.5313	24.5760
110172	23.3730	23.6803	24.7005	23.9332
110174	13.7339	14.6199	*	14.1346
110177	20.7187	21.2796	22.7831	21.6138
110178	18.8306	*	*	18.8306
110179	22.7841	22.0767	24.3673	23.0370
110181	14.0941	12.9798	13.9591	13.6986
110183	23.3826	22.5148	24.2899	23.3905
110184	22.1970	22.1920	22.2761	22.2235

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
110185	16.7246	17.7925	17.3330	17.2705
110186	17.4287	18.3178	19.7172	18.4775
110187	20.1154	19.8419	22.8248	20.9454
110188	24.8376	23.7032	22.0258	23.3741
110189	22.2715	20.8786	19.8454	20.8993
110190	18.5728	18.3649	20.7292	19.1518
110191	20.2033	21.4033	21.3404	21.0040
110192	21.4951	21.0486	22.9684	21.8761
110193	20.6380	20.7867	22.1477	21.1908
110194	15.1480	14.8115	15.8129	15.2645
110195	13.9135	12.7261	10.9444	12.3540
110198	24.1999	24.8646	24.8275	24.6410
110200	18.1862	17.7744	17.9631	17.9701
110201	20.4699	20.9497	21.9313	21.1039
110203	26.8148	22.7453	24.2062	24.5686
110204	19.7317	30.7342	35.3699	24.8432
110205	21.1435	21.3617	20.1405	20.8862
110207	12.9727	14.7154	14.6045	14.1130
110208	15.1742	15.6161	15.0350	15.2676
110209	17.9190	18.6404	20.0629	18.7585
110211	20.9372	26.9151	20.1024	22.3126
110212	11.8545	14.3790	15.8420	13.8932
110213	14.3651	*	*	14.3651
110215	20.1928	18.1539	21.0263	19.7770
110216	*	27.1878	*	27.1877
120001	27.9213	29.0427	29.4126	28.7754
120002	25.0744	25.2021	23.5667	24.5781
120003	25.9059	23.9115	24.6238	24.8142
120004	23.9208	24.8632	26.1398	24.8838
120005	23.3975	24.1662	22.3213	23.2601
120006	25.0895	25.8943	26.6302	25.8359
120007	22.7200	22.8772	22.7179	22.7718
120009	17.4693	16.4485	16.7630	16.8820
120010	25.1480	24.1923	24.9089	24.7414
120011	35.0582	37.2759	35.2051	35.8314
120012	23.1144	21.8507	22.0371	22.3824
120014	22.8866	24.1208	25.3557	24.0761
120015	32.9906	42.6465	*	37.0469
120016	27.9127	45.1899	43.5083	34.2774
120018	24.5031	31.1879	*	26.7466
120019	22.9341	25.5659	23.8535	24.0876
120021	23.4508	23.1839	36.8286	25.9002
120022	21.7868	19.2614	22.2781	21.0242
120024	29.4808	32.2514	21.9657	28.3802
120025	20.1065	50.6376	40.1332	25.3493
120026	26.0787	25.1314	25.7023	25.6323
120027	24.7255	24.4535	23.1434	24.0841
120028	27.5023	27.0897	27.5365	27.3898
130001	18.8471	17.6306	19.6328	18.7161
130002	16.6620	16.9867	18.5746	17.4270
130003	21.7313	22.3430	23.0994	22.4005
130005	20.7169	21.2386	22.6364	21.5043
130006	19.3392	20.4614	21.4640	20.4603
130007	20.8338	21.8107	22.0894	21.5806
130008	12.5506	13.6018	19.3392	14.7112
130009	19.1837	15.9701	20.8748	18.5462
130010	17.6795	17.5119	17.7826	17.6635
130011	20.5031	20.1147	22.1125	20.9248
130012	22.9813	24.9976	24.2451	24.1243
130013	17.4038	15.1129	22.6624	18.2887
130014	18.9769	19.2107	19.8240	19.3628
130015	15.7233	18.5913	16.4136	16.7965
130016	17.3942	19.0516	20.1220	18.8309
130017	17.1710	19.6875	19.9511	18.7336
130018	19.7368	19.8425	20.0563	19.8848
130019	18.6648	19.1711	19.5147	19.0953

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
130021	12.8588	15.6155	14.4430	14.2958
130022	16.5270	18.9127	19.7814	18.3410
130024	19.3634	19.0703	19.9934	19.4905
130025	17.5213	16.4627	17.5989	17.2009
130026	21.5934	21.8106	23.2093	22.2042
130027	21.4279	20.5344	20.6641	20.8743
130028	19.1093	20.9674	21.2217	20.4234
130029	18.4263	18.7694	22.9243	19.6491
130030	17.8440	17.5759	18.5827	17.9732
130031	16.2397	16.7766	20.4146	17.4242
130034	16.9873	18.9483	20.5802	18.9102
130035	19.3478	20.7770	17.2864	19.2295
130036	13.7933	13.6362	15.1590	14.2304
130037	18.8071	18.6856	19.2108	18.9127
130043	16.5102	16.7904	17.6920	16.9853
130044	17.8160	13.4513	18.7067	16.5045
130045	16.0990	19.0208	17.5152	17.4280
130048	16.0899	16.7900	*	16.4201
130049	20.3129	22.4440	22.0520	21.6192
130054	17.2729	17.7085	16.4675	17.1120
130056	14.6862	20.9476	28.8008	19.9051
130060	21.8662	22.7399	23.2512	22.6187
130061	15.4006	14.7394	*	15.1267
130062	16.5672	19.8157	19.8264	18.8380
130063	15.9441	18.8024	18.4797	18.1425
140001	16.3372	17.7990	18.1511	17.3657
140002	19.0248	19.9284	20.9959	19.9709
140003	21.2886	17.8595	18.0163	18.9220
140004	15.7042	17.4574	18.9713	17.4061
140005	11.6127	12.3002	12.4144	12.1009
140007	22.9799	23.8585	24.9847	23.9721
140008	21.6548	22.1111	24.2634	22.6646
140010	31.8207	28.5635	28.0863	29.4098
140011	17.8676	18.6164	18.4052	18.3022
140012	23.0653	21.4374	22.5885	22.3529
140013	18.3060	19.6722	20.3147	19.4284
140014	22.4737	21.4042	22.2944	22.0537
140015	16.6735	17.6805	20.3540	18.1726
140016	13.1278	14.4938	15.4454	14.3266
140018	22.3070	22.4132	23.4062	22.7146
140019	16.6548	16.4254	16.1180	16.3909
140024	16.8271	15.3782	16.1032	16.1040
140025	16.9462	18.5135	21.7775	18.9319
140026	16.6612	18.3220	19.7839	18.2263
140027	18.7553	19.2149	20.5980	19.5140
140029	22.8322	26.0833	28.5670	25.8242
140030	21.9475	23.1760	25.3715	23.5785
140031	19.5731	17.6067	16.9650	17.9987
140032	18.1058	19.0383	19.8033	18.9961
140033	24.1722	25.1639	22.8705	24.0049
140034	19.5278	19.8792	19.7711	19.7256
140035	15.2649	15.5040	17.4514	16.0631
140036	18.5771	19.1076	21.2366	19.6677
140037	13.0764	14.1083	14.3082	13.8255
140038	18.3035	18.4948	19.8197	18.8624
140040	19.9267	16.7450	18.0342	18.2044
140041	17.6582	18.5952	18.8042	18.3411
140042	15.4095	15.8892	16.1157	15.8051
140043	19.4683	20.1176	21.7356	20.4389
140045	15.5807	17.7799	17.4261	16.8835
140046	18.9763	18.6371	20.0859	19.2505
140047	17.1539	13.3610	16.6672	15.5612
140048	24.0913	23.9545	23.8652	23.9681
140049	28.4958	26.9483	26.7160	27.4301
140051	23.8264	24.0796	24.7180	24.2214
140052	19.6409	17.9571	21.0450	19.4727

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
140053	19.1892	19.9620	20.9768	20.0131
140054	22.1921	23.1576	23.9459	23.0869
140055	16.3404	14.3603	15.8756	15.4931
140058	17.4927	18.6861	19.1199	18.4367
140059	15.0195	*	18.2593	16.6820
140061	17.3012	18.2039	18.4264	17.9767
140062	28.0877	28.5304	28.6390	28.4255
140063	25.3641	29.1453	29.6998	27.8767
140064	19.1023	18.9379	19.6954	19.2477
140065	24.1128	25.3336	25.5939	25.0012
140066	17.3902	13.6491	15.4818	15.3710
140067	19.3267	19.5292	20.7511	19.8509
140068	19.9691	21.6188	22.3622	21.2834
140069	16.7544	17.3879	17.7785	17.3221
140070	22.9678	22.7153	25.2646	23.5870
140074	19.3504	21.6052	22.2563	20.9569
140075	21.6313	21.6434	21.8472	21.6925
140077	17.5305	17.3647	17.3236	17.4081
140079	23.3020	23.6928	22.7046	23.2149
140080	21.0739	22.1968	22.0682	21.7613
140081	16.2247	16.9808	18.1746	17.0842
140082	23.8960	29.7262	26.5960	26.4591
140083	19.3145	21.0330	20.7704	20.3580
140084	20.9709	22.3467	23.0263	22.0990
140086	18.3803	19.1613	19.1815	18.9175
140087	16.1009	17.1147	21.4593	18.0959
140088	25.2369	25.4176	26.5258	25.7146
140089	17.6366	18.3157	19.3230	18.4019
140090	26.4325	26.9364	28.0530	26.9854
140091	20.9018	21.9322	23.5559	22.1482
140093	18.2899	20.1528	20.7564	19.6330
140094	21.4709	21.9383	22.8892	22.0901
140095	24.0549	24.2859	25.5716	24.6269
140097	17.5081	21.1719	21.8418	20.1374
140100	21.3581	23.1399	23.8226	22.7460
140101	21.5473	21.4211	23.1418	22.0459
140102	17.1500	17.5729	18.6328	17.7567
140103	19.2783	18.1303	19.1834	18.8678
140105	22.6573	22.8944	23.8258	23.1227
140107	13.7533	11.8383	11.5827	12.2495
140108	25.4742	26.9971	27.9140	26.8421
140109	15.7465	14.5498	15.9178	15.3965
140110	19.1822	19.2888	20.9631	19.8004
140112	17.6856	17.6974	18.1119	17.8311
140113	19.0592	19.5584	26.2393	21.3762
140114	21.1639	21.0976	23.0383	21.7813
140115	21.1926	21.0433	20.4587	20.8982
140116	23.1177	23.8993	25.5980	24.2533
140117	21.5671	21.4876	22.0889	21.7249
140118	23.5952	24.3260	25.3249	24.4123
140119	29.1419	27.9145	30.6468	29.2072
140120	18.0743	17.9716	17.7667	17.9340
140121	16.0397	16.6993	16.2607	16.3273
140122	24.6470	26.1270	26.7882	25.8138
140124	27.1906	27.9813	30.6820	28.5176
140125	17.6759	16.9516	17.8190	17.4826
140127	19.8973	20.0489	20.8397	20.2623
140128	19.4955	23.1327	23.5481	22.1101
140129	18.2639	20.2868	21.6252	19.9926
140130	22.2285	23.4298	26.0464	23.9518
140132	23.5475	23.3054	23.7046	23.5171
140133	21.4090	21.4166	20.1740	21.0117
140135	17.8100	17.3985	18.2479	17.8298
140137	16.8969	18.6330	20.4807	18.6235
140138	16.7420	17.1968	14.5771	16.0861
140139	14.0619	11.0397	*	12.4249

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
140140	17.8243	17.6845	18.8185	18.1076
140141	17.5204	19.1097	20.2606	18.9480
140143	19.1862	19.0810	19.9885	19.4222
140144	21.3245	22.2864	24.8854	22.7447
140145	17.5471	18.1788	19.4509	18.3977
140146	21.9573	19.9704	19.4272	20.3714
140147	16.1336	18.8049	17.1013	17.2344
140148	18.6598	18.7730	19.7630	19.0696
140150	27.3378	24.7976	28.9853	26.8988
140151	21.3896	20.0310	20.8820	20.7518
140152	24.6333	25.6011	28.3946	26.1493
140155	19.9738	20.2778	13.0438	17.2026
140158	22.7639	22.7988	23.7428	23.1140
140160	17.7691	17.7921	19.8825	18.5234
140161	20.0948	20.3799	21.2045	20.5610
140162	19.6464	20.3452	21.6901	20.5431
140164	18.7806	18.6589	19.8246	19.1100
140165	14.9156	14.7223	16.3700	15.3419
140166	17.5496	18.3833	19.3672	18.4196
140167	17.1479	17.6525	18.8532	17.9029
140168	16.6770	17.7453	18.2896	17.5820
140170	16.1621	16.4107	17.6901	16.7412
140171	14.1637	15.0237	15.2617	14.8002
140172	23.8431	23.6262	24.8587	24.0563
140173	15.1487	16.3924	16.0030	15.8459
140174	20.5339	35.9320	22.0418	24.0179
140176	23.2866	24.5338	26.3468	24.7221
140177	18.2648	15.0827	20.3142	17.5964
140179	21.1948	21.9859	22.7345	21.9641
140180	22.4548	22.7996	22.7508	22.6646
140181	20.8709	21.9864	22.6643	21.8357
140182	22.0170	28.9515	25.1302	24.9068
140184	17.8155	17.2401	17.9169	17.6582
140185	17.6514	18.2867	18.8573	18.2635
140186	22.7890	23.5034	25.6807	23.9584
140187	17.9201	18.3331	19.4049	18.5535
140188	15.2479	16.1907	*	15.6443
140189	21.0616	20.6627	21.1515	20.9599
140190	16.3366	17.5263	16.6673	16.8245
140191	25.8835	25.2628	27.4166	26.1852
140193	15.8022	17.4057	18.5651	17.2695
140197	18.6394	19.3774	19.9406	19.3426
140199	18.3507	18.0450	18.5409	18.3150
140200	21.5220	21.7680	22.4626	21.9362
140202	22.1939	23.7955	25.2777	23.7942
140203	19.9194	21.0848	24.8870	21.9324
140205	17.4751	20.0784	*	18.5139
140206	21.3295	22.5109	22.8223	22.2246
140207	21.9779	22.3905	25.4539	23.1447
140208	25.9900	26.2527	28.3112	26.8566
140209	18.1206	20.1557	20.2433	19.4720
140210	15.6899	14.8248	15.5345	15.3479
140211	21.8891	22.6265	22.8852	22.4887
140213	27.0645	24.9892	25.6839	25.9086
140215	15.9949	15.2893	18.5502	16.5949
140217	24.8229	25.7329	25.9030	25.4763
140218	14.9459	14.9851	17.4171	15.7345
140220	17.6370	17.8450	19.3915	18.3036
140223	24.9249	24.9017	26.2168	25.3383
140224	25.8668	32.8292	25.6766	27.8908
140228	19.6988	20.1688	21.8627	20.5743
140230	18.0918	18.2983	12.3494	15.7704
140231	23.9176	24.5019	26.0208	24.9246
140233	19.4542	21.2333	24.4419	21.6980
140234	18.9945	*	19.7266	19.3554
140236	*	12.9253	*	12.9252

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
140239	18.8127	20.3745	21.6074	20.3069
140240	23.6860	24.6949	25.1418	24.5193
140242	24.5428	25.2317	26.1850	25.3655
140245	13.4839	14.2481	15.1320	14.2800
140246	13.4639	11.6267	15.0650	13.2908
140250	25.0876	23.6449	25.3410	24.6985
140251	21.4385	21.9435	23.5128	22.3081
140252	25.2246	25.0220	26.4715	25.5870
140253	18.5511	19.5858	18.4567	18.8447
140258	23.2973	25.3622	25.0743	24.5818
140271	15.5079	12.0079	16.0350	14.2915
140275	20.1699	23.8171	22.9656	22.2969
140276	26.6777	25.3134	26.1713	26.0267
140280	20.2360	18.8300	20.0763	19.6936
140281	24.0192	25.2719	26.5197	25.2957
140285	18.1181	18.5916	15.7435	17.3779
140286	20.3735	26.1290	24.0368	23.4605
140288	25.2327	24.4331	25.8717	25.1876
140289	17.1388	18.1747	17.7886	17.7207
140290	21.1784	22.8590	26.5055	23.5505
140291	25.0911	24.9537	26.8628	25.6578
140292	20.8560	21.9950	26.8610	23.2005
140294	17.7226	17.7301	19.4218	18.2830
140300	25.3662	27.8436	28.9830	27.4142
150001	22.8109	24.0620	22.6875	23.1822
150002	19.3401	20.7651	20.7353	20.3004
150003	19.7661	20.8636	21.4649	20.6945
150004	20.3685	21.2449	22.8060	21.4609
150005	20.6260	21.6806	22.8149	21.7447
150006	20.8158	20.6523	21.8435	21.1085
150007	20.1826	20.6635	21.2811	20.6934
150008	21.4545	21.8457	23.0208	22.1136
150009	18.7073	19.0030	19.5869	19.1023
150010	21.7125	20.5570	21.2466	21.1746
150011	18.3742	18.3275	19.9096	18.8524
150012	22.4751	22.1402	21.7903	22.1209
150013	17.0352	16.9327	17.5531	17.1857
150014	22.0143	21.5168	22.8402	22.1055
150015	22.5409	21.9037	24.2370	22.8616
150017	18.7664	19.5339	20.6758	19.6741
150018	20.4947	21.0496	22.8922	21.5205
150019	16.6327	17.8585	19.8341	18.0075
150020	15.1120	16.6600	15.9405	15.8686
150021	19.5096	21.5944	23.3800	21.5139
150022	19.1555	17.9222	18.7751	18.6044
150023	18.3598	19.3412	20.3015	19.3319
150024	18.4140	19.2295	19.8368	19.1528
150025	17.7007	20.2750	*	18.8948
150026	18.8417	22.4978	21.9448	21.0269
150027	17.3284	18.0335	19.4238	18.2383
150029	23.0546	23.2454	24.8939	23.7166
150030	17.9992	19.2406	20.7256	19.3281
150031	17.2429	18.3463	21.3494	18.9577
150033	21.8768	22.6741	23.0756	22.5535
150034	22.1317	23.1533	23.3718	22.8966
150035	20.4477	21.2374	22.3779	21.3734
150036	20.8692	21.4567	22.1464	21.5046
150037	21.7109	24.4611	22.3699	22.8076
150038	21.2193	22.0572	20.3454	21.1795
150039	18.4729	19.6215	16.0227	17.8696
150042	18.1632	20.2221	18.0185	18.7252
150043	19.0120	20.1741	20.6301	19.8897
150044	18.4381	19.1309	19.8951	19.1600
150045	16.8121	18.1670	20.6406	18.4832
150046	17.6342	18.2543	19.4146	18.4518
150047	19.7441	22.0145	21.9824	21.1814

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
150048	19.3329	19.1648	21.1441	19.9048
150049	17.0141	18.6451	21.6309	18.9803
150050	16.8354	17.7354	18.0411	17.5369
150051	19.0130	19.7257	20.6895	19.8190
150052	15.8590	17.3750	18.8345	17.3836
150053	19.1421	18.8632	18.3493	18.7874
150054	17.3825	18.3916	19.3424	18.3843
150056	22.4087	21.5774	23.0603	22.3391
150057	16.5882	16.9736	17.4044	16.9907
150058	20.8178	22.1409	23.0273	22.0105
150059	21.2535	22.7360	23.1398	22.3623
150060	17.0743	18.6159	19.5011	18.4069
150061	17.3887	19.7968	19.4014	18.8242
150062	20.5415	20.8274	21.2608	20.9059
150063	22.0925	22.6525	24.8587	23.1574
150064	18.1400	20.3865	20.6232	19.7087
150065	19.8913	21.2153	21.4572	20.8676
150066	15.3373	19.5313	19.6845	18.2239
150067	18.2926	18.8862	20.5000	19.2693
150069	21.5310	23.3969	23.5510	22.9021
150070	17.9260	18.0827	18.9332	18.3136
150071	13.4760	13.5111	16.4179	14.3733
150072	16.2054	15.0765	18.5813	16.5238
150073	22.2968	*	19.8034	21.0773
150074	20.4175	20.2305	21.3500	20.6570
150075	15.5603	16.7532	17.2267	16.4858
150076	22.9382	22.6424	23.3724	22.9988
150078	19.2718	19.9668	20.2068	19.8183
150079	17.2436	18.2051	18.3668	17.9396
150082	17.5265	17.8381	19.6881	18.3251
150084	23.2506	24.3107	24.9529	24.2038
150086	18.9735	18.3838	19.7763	19.0552
150088	18.9869	20.3366	22.3055	20.5100
150089	23.8791	22.1725	21.5664	22.4947
150090	20.7726	21.0945	21.9803	21.2765
150091	20.4053	22.4640	26.5235	23.0637
150092	16.7434	16.9179	18.2592	17.3164
150094	16.5788	17.5244	16.8351	16.9693
150095	17.1324	19.2749	22.3214	19.5343
150096	23.2764	20.8204	*	21.9551
150097	19.3802	19.7751	21.1462	20.1553
150098	15.0943	15.2829	16.4763	15.6011
150099	22.4229	*	*	22.4229
150100	18.4148	19.8066	18.7289	18.9950
150101	16.4604	20.6209	21.2025	19.3973
150102	19.7426	23.7180	20.8818	21.3162
150103	18.4781	18.7036	19.3653	18.9170
150104	17.6981	20.0765	21.3141	19.7260
150105	20.0431	22.4412	21.6975	21.3454
150106	16.1510	16.8714	18.7088	17.2750
150109	18.8077	19.9066	21.7870	20.1411
150110	18.6627	21.9336	*	20.0654
150111	18.4556	19.2355	24.1559	20.4298
150112	20.4109	20.5253	22.1939	21.0672
150113	20.3780	19.6603	20.5871	20.2207
150114	19.5183	17.9877	18.3097	18.6233
150115	17.4315	18.4844	18.1308	18.0117
150122	18.7139	17.7867	20.7540	19.0652
150123	14.1105	14.0508	16.2898	14.8865
150124	14.6245	15.9487	16.2104	15.6060
150125	20.6735	21.3311	22.0299	21.3571
150126	21.3697	20.6857	24.0000	22.0092
150127	17.1994	17.0052	18.0532	17.4224
150128	18.5100	19.5576	20.4742	19.4866
150129	24.7711	28.6211	29.9888	27.3320
150130	18.1971	18.4846	18.3852	18.3505

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
150132	20.1684	20.9443	21.2747	20.8045
150133	17.3966	18.4250	20.0320	18.5328
150134	19.2526	19.3632	20.2764	19.6091
150136	20.1245	21.8097	22.9091	21.6195
150145	16.6851	*	*	16.6851
150146	*	19.0204	*	19.0204
160001	18.6035	19.0085	20.1699	19.2573
160002	15.9534	16.6003	17.6600	16.7287
160003	16.0862	16.2208	17.5429	16.6099
160005	17.6153	17.9405	19.3348	18.3156
160007	13.2101	15.1738	14.9137	14.4341
160008	15.9742	16.6193	16.7863	16.4539
160009	16.8391	17.9886	19.0664	17.9375
160012	16.4827	16.7112	17.9236	17.0145
160013	18.3996	18.6304	20.3023	19.1017
160014	15.9086	16.7146	18.7253	17.0747
160016	19.6322	19.9747	21.6050	20.4119
160018	14.5946	15.6141	16.0793	15.4308
160020	15.4712	15.5384	15.7960	15.6015
160021	16.5049	16.7617	16.7920	16.6812
160023	15.0665	15.0099	15.3854	15.1530
160024	19.7050	19.4764	20.5622	19.9066
160026	18.8379	19.5260	20.4567	19.6047
160027	16.3477	16.9417	18.2081	17.1431
160028	19.9595	21.0000	22.9000	21.2124
160029	20.4678	21.3457	22.2106	21.3395
160030	19.9508	19.6182	21.6899	20.4018
160031	15.2448	16.1267	16.8957	16.0812
160032	17.3202	18.3168	19.2464	18.2782
160033	18.8673	18.8859	20.1916	19.3159
160034	15.0019	16.5957	17.3644	16.3397
160035	15.2211	16.3991	17.0165	16.0816
160036	17.8849	17.4558	20.2598	18.5977
160037	19.0532	19.5045	19.5067	19.3582
160039	17.4758	17.8647	19.1998	18.1868
160040	18.1949	18.0667	19.6339	18.6033
160041	16.7850	17.4435	18.7943	17.7638
160043	15.6909	14.8564	16.7841	15.7684
160044	16.7439	17.8323	19.5552	18.0882
160045	20.1236	20.0611	21.4757	20.5590
160046	14.5655	16.2737	16.8665	15.8592
160047	18.3593	19.0787	20.4259	19.2869
160048	14.6144	15.6856	17.2709	15.7797
160049	14.5457	15.5673	15.3233	15.1526
160050	17.4912	17.7878	21.1184	18.6885
160051	14.6400	16.4261	15.8213	15.6207
160052	18.0941	21.7647	22.1933	20.7461
160054	16.1753	16.1981	16.5258	16.3024
160055	14.7600	15.1674	17.6177	15.8187
160056	16.1575	17.0172	17.9534	17.0042
160057	18.1776	19.1378	19.6802	19.0270
160058	21.1159	22.1061	22.2812	21.8210
160060	16.0436	17.2825	17.7489	16.9862
160061	17.3215	17.0938	17.2064	17.2123
160062	17.8086	17.4388	18.8163	18.0222
160063	16.8834	16.3583	17.3771	16.8779
160064	20.5496	22.2131	25.2962	22.5781
160065	16.9373	17.1043	17.0609	17.0424
160066	17.1875	17.9971	19.3202	18.1697
160067	17.8514	16.7833	17.6602	17.4022
160068	17.9892	19.0572	20.5995	19.2056
160069	19.7280	19.1640	20.5989	19.8301
160070	16.7017	18.4588	17.7855	17.6458
160072	14.9536	14.4141	15.3384	14.9054
160073	11.8261	11.4997	15.5946	12.7126
160074	19.5092	17.9513	18.4624	18.6658

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
160075	19.4948	18.4613	20.7842	19.5335
160076	17.9381	17.8824	19.1590	18.2977
160077	12.8826	13.6658	15.0468	13.8624
160079	17.6187	18.6333	20.5010	18.9292
160080	18.6687	19.4925	19.6680	19.2860
160081	17.0052	17.4466	19.1442	17.8781
160082	19.6499	19.5322	20.7306	19.9632
160083	20.6189	19.7542	21.3221	20.5512
160085	18.0063	21.2557	19.1929	19.4359
160086	17.3271	17.5308	19.0477	17.9338
160088	20.2331	22.3655	23.8098	22.1152
160089	16.9538	17.3449	18.3526	17.5556
160090	17.1090	17.9614	18.4210	17.8146
160091	12.8516	14.2573	14.8904	13.9759
160092	15.5011	17.0633	17.9251	16.7839
160093	17.7457	18.5675	19.5732	18.6194
160094	18.7653	17.6094	18.7835	18.3744
160095	15.1895	15.2722	16.4927	15.6525
160097	15.9263	16.6790	17.7860	16.8002
160098	16.3135	16.8670	16.8997	16.6946
160099	13.9053	15.0880	16.0710	15.0169
160101	18.3705	18.9788	19.6314	18.9647
160102	18.8765	20.1161	14.4837	17.6011
160103	17.0973	18.2741	19.6168	18.2567
160104	18.8301	17.4829	21.0060	19.1043
160106	16.9639	17.3474	19.4385	17.8892
160107	18.0634	18.0097	18.8936	18.3269
160108	16.0529	16.7779	17.7577	16.8631
160109	16.5593	17.9873	18.2938	17.5854
160110	19.1420	20.6215	20.9959	20.2817
160111	14.1644	14.9965	15.1104	14.7432
160112	16.8332	17.2450	19.6950	17.9037
160113	14.7097	15.4834	14.9449	15.0474
160114	16.1423	16.5006	18.0532	16.8768
160115	15.8995	16.5654	16.9991	16.4863
160116	16.9534	16.6993	18.4261	17.3468
160117	17.9410	18.7615	20.1682	18.9384
160118	17.2523	19.4472	17.1480	17.8721
160120	10.5992	15.6789	15.0577	13.1432
160122	18.9252	18.1469	18.8469	18.6451
160124	18.0908	19.1600	19.9144	19.0634
160126	17.8142	19.4903	17.8643	18.3076
160129	16.7131	17.2112	18.0113	17.3098
160130	16.0528	15.6666	16.2628	15.9955
160131	15.4898	16.0424	16.5397	16.0265
160134	13.4743	15.3012	14.6396	14.4558
160135	18.2682	18.7711	18.3973	18.4829
160138	16.8699	17.1491	18.3957	17.4264
160140	18.4007	18.5630	19.6155	18.8655
160142	16.2875	18.1467	17.2792	17.2139
160143	16.6154	17.4497	18.1287	17.4014
160145	13.9152	16.9092	17.8887	16.1391
160146	16.6024	17.7010	19.0576	17.7319
160147	17.4880	19.4041	21.6062	19.3700
160151	16.8257	17.2177	18.3398	17.4331
160152	15.6170	15.9500	17.0750	16.1956
160153	20.2316	21.2085	22.7004	21.3705
170001	17.9304	17.9218	18.5120	18.1317
170004	15.0636	16.1442	17.2262	16.1274
170006	17.2192	17.5982	19.1982	18.0168
170008	14.9124	16.8412	17.7061	16.4380
170009	20.7795	23.1349	25.0508	23.0721
170010	18.7384	19.4584	19.5990	19.2633
170012	17.8719	18.4432	20.2412	18.8687
170013	18.6454	19.4667	20.1852	19.4537
170014	17.9349	18.4931	19.6044	18.6936

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
170015	16.5750	17.1302	17.2443	16.9768
170016	19.2130	20.0675	22.1023	20.4287
170017	17.7958	19.5994	19.7908	19.0428
170018	15.2984	15.3237	14.8794	15.1619
170019	15.2094	16.9362	17.4699	16.5180
170020	17.3400	18.1325	19.1418	18.2290
170022	18.5309	19.1888	20.3269	19.3395
170023	19.1351	19.2441	19.6533	19.3514
170024	13.6803	14.3604	15.0081	14.3388
170025	17.8667	18.7182	19.1720	18.5412
170026	15.0470	14.8974	16.9094	15.6079
170027	17.3604	17.8690	18.4466	17.8805
170030	14.6530	15.9282	12.9413	14.4010
170031	13.9601	14.2151	16.4660	14.7972
170032	15.6093	16.3449	15.2207	15.7224
170033	16.4059	19.1952	20.4533	18.7304
170034	15.8202	16.9586	17.8239	16.8326
170035	18.5885	17.0945	19.8334	18.5082
170038	14.7776	13.8582	15.2505	14.6401
170039	15.8635	17.0774	18.5780	17.1811
170040	21.6440	21.0617	23.1014	21.8449
170041	11.7566	12.4488	9.9263	11.2790
170044	15.3011	17.3254	*	16.3356
170045	14.0875	25.8331	20.5454	19.8078
170049	19.9415	20.7921	21.2917	20.7035
170051	15.0889	16.4851	16.9003	16.1546
170052	15.0108	15.2283	16.0948	15.4803
170053	16.5102	14.6133	14.3628	15.2080
170054	14.4353	14.6354	15.2814	14.7841
170055	16.9800	18.2607	18.1783	17.7932
170056	17.0442	18.3550	19.7369	18.3732
170057	13.0007	*	*	13.0007
170058	18.6983	19.5415	20.1090	19.4664
170060	17.3482	18.9853	17.5290	17.8991
170061	15.6527	15.0258	15.6412	15.4439
170063	12.8082	14.1185	13.7611	13.4911
170066	15.5322	16.2891	16.8009	16.1505
170067	14.7492	14.9921	20.7945	16.7328
170068	15.1790	17.0022	19.2629	17.0101
170070	14.2445	14.0627	14.8348	14.3652
170072	12.6329	12.7709	*	12.7037
170073	17.5368	17.7056	17.7586	17.6632
170074	17.5537	17.3699	17.6543	17.5273
170075	12.4212	13.6816	14.4939	13.5832
170076	14.5866	14.6109	14.9392	14.7111
170077	13.5235	13.9104	14.1376	13.8508
170079	13.5261	11.5902	16.7227	13.6766
170080	12.6014	14.8293	13.6794	13.6471
170081	13.8077	14.6823	15.0840	14.5566
170082	12.8563	13.7462	14.8154	13.7610
170084	12.5410	13.0519	13.6517	13.0693
170085	15.4518	17.5422	21.8907	18.4877
170086	20.4068	19.7182	20.7298	20.2879
170088	13.4542	13.4860	*	13.4703
170089	18.8136	15.4860	20.2263	18.3293
170090	11.9147	10.9444	23.6837	13.5581
170093	13.5490	14.0276	14.7803	14.0852
170094	20.1985	21.2035	21.2484	20.8944
170095	15.5463	15.3532	16.1078	15.6715
170097	16.4608	17.7540	18.6023	17.6032
170098	15.5259	16.6210	17.3480	16.4881
170099	13.6033	14.3370	16.5247	14.7568
170101	14.5629	18.0143	17.3381	16.4637
170102	13.6321	14.2447	14.4499	14.1084
170103	17.2844	17.9530	18.6172	17.9709
170104	20.6182	21.0049	22.0671	21.2397

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
170105	16.5408	16.7403	18.2788	17.1877
170106	18.5479	17.7467	*	18.0680
170109	17.2629	16.9782	18.3483	17.5682
170110	16.9823	18.5731	21.0637	18.8359
170112	14.3855	15.4049	15.8097	15.1873
170113	13.9038	14.6486	16.4938	15.0142
170114	14.4545	16.2645	13.9726	14.8012
170115	12.6997	12.9216	13.0253	12.8848
170116	16.8714	18.1830	19.4278	18.1442
170117	15.7875	16.8237	16.8301	16.4481
170119	15.1990	15.2708	15.1982	15.2222
170120	17.6748	17.4917	18.2832	17.8028
170122	20.0615	21.1769	21.4588	20.8791
170123	23.1697	23.6534	25.2122	23.9595
170124	11.1249	15.0596	16.3925	13.8286
170126	12.8096	13.5736	14.5527	13.6140
170128	14.8891	14.1676	17.6259	15.4144
170131	10.1000	*	*	10.1000
170133	18.0243	18.8119	19.9778	18.9214
170134	14.1085	14.6799	15.1932	14.6538
170137	17.8290	19.3118	19.3344	18.8395
170139	14.1967	14.3001	14.8157	14.4193
170142	*	17.7134	19.0547	18.3947
170143	15.6509	16.0415	16.3258	16.0049
170144	19.0929	20.4392	20.8488	20.0997
170145	17.1837	19.0142	20.1494	18.7616
170146	20.9075	21.7919	25.2520	22.7252
170147	22.3017	17.6717	18.4634	19.3887
170148	16.9183	19.1942	24.4828	19.5145
170150	15.5651	15.9072	14.9718	15.4692
170151	13.8934	14.3668	14.5002	14.2317
170152	14.9139	15.6423	16.0930	15.5503
170160	13.7108	14.4732	17.0629	15.0179
170164	16.6542	17.4072	17.0791	17.0445
170166	27.5567	12.7507	16.5113	18.0323
170171	12.5200	13.1792	14.7051	13.3708
170175	19.0232	20.1907	20.8671	20.0207
170176	21.3400	23.5043	23.5743	22.8029
170180	16.6921	8.6352	*	11.8552
170182	22.2164	21.3454	21.9797	21.8339
170183	20.3505	19.5182	16.6577	18.5979
170185	*	*	26.8136	26.8136
170186	*	*	33.2457	33.2457
180001	17.9906	20.4885	20.8169	19.8393
180002	17.9669	17.5798	19.8195	18.4259
180004	17.2581	17.7149	18.0494	17.6734
180005	21.1390	22.4634	23.4941	22.1458
180006	11.4398	10.3400	11.2872	11.0389
180007	17.6776	17.9491	18.6823	18.0973
180009	21.4730	21.0608	21.7746	21.4458
180010	19.1100	19.6311	19.4210	19.3847
180011	17.1050	19.0526	22.6798	19.8513
180012	18.7223	19.0646	19.6614	19.1485
180013	18.2354	19.7418	20.0950	19.3760
180014	21.4856	21.3361	23.0067	21.8859
180016	19.8892	21.1458	19.7242	20.2686
180017	15.4140	15.6583	16.7649	15.9422
180018	17.1692	15.4892	18.1529	16.9235
180019	17.3970	17.8285	19.5953	18.2719
180020	17.7288	18.0111	19.4391	18.3612
180021	15.4580	17.0618	16.5376	16.3552
180023	15.8803	17.4717	19.0574	17.4610
180024	16.1731	16.5040	19.6313	17.2961
180025	14.1841	15.4180	17.1875	15.5888
180026	14.6804	15.0118	13.9959	14.5545
180027	16.4116	17.5286	19.6928	17.8399

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
180028	19.5276	15.7005	26.2220	19.5655
180029	17.7729	17.7248	20.0841	18.4982
180030	17.3430	17.9543	17.5043	17.5959
180031	13.9844	13.1848	17.1003	14.4541
180032	16.8318	17.2784	17.2362	17.1383
180033	17.7344	15.4131	17.0498	16.6984
180034	15.3369	16.3991	17.0349	16.2188
180035	20.1305	21.3666	22.4651	21.2939
180036	19.8398	20.1860	20.6951	20.2522
180037	19.9737	21.2184	21.0177	20.7450
180038	17.7626	18.5923	19.3837	18.5916
180040	19.5337	21.2229	22.2270	20.9835
180041	15.0785	16.3699	17.5950	16.3724
180042	16.7691	17.1519	15.5660	16.4438
180043	16.8027	14.6526	17.2414	16.1261
180044	18.5571	19.4984	21.1057	19.7654
180045	17.7130	20.8455	20.7498	19.9529
180046	19.2523	21.2080	21.6955	20.6999
180047	16.2304	18.6938	17.8625	17.5927
180048	18.3442	17.7816	18.3151	18.1431
180049	16.4319	16.5459	17.8418	16.9262
180050	17.8540	17.1493	19.4992	18.1665
180051	16.3960	17.5441	18.3028	17.4095
180053	15.9284	15.8994	17.3167	16.3733
180054	19.4858	20.0946	17.4354	19.0288
180055	15.2663	15.8422	16.6072	15.8890
180056	17.0056	17.5881	18.7038	17.7559
180058	15.9685	14.5355	14.8840	15.0687
180059	13.3955	14.7032	17.2542	14.9522
180063	13.1036	12.4448	14.7338	13.4418
180064	15.2424	15.5066	16.3894	15.6781
180065	12.0629	11.1934	11.0966	11.4164
180066	19.2981	19.8956	20.7907	19.9622
180067	20.6322	20.1712	20.2762	20.3589
180069	17.7911	16.2916	19.0836	17.6936
180070	13.1923	15.9362	15.4643	14.7849
180072	16.9021	17.2347	17.0576	17.0759
180078	21.1170	21.7116	23.7765	22.2300
180079	15.1636	15.9048	18.1683	16.3817
180080	16.4989	16.6428	17.6735	16.9434
180087	14.9167	15.6089	16.2378	15.5798
180088	22.0374	22.1774	22.8908	22.3519
180092	18.2405	18.3597	18.8964	18.5113
180093	17.0132	17.8492	17.7592	17.5305
180094	13.5490	13.6233	14.3306	13.8326
180095	13.8021	13.9050	15.4478	14.3114
180099	13.3631	13.2991	14.0464	13.5559
180101	18.4883	*	21.0704	19.8124
180102	17.9618	18.5240	18.8169	18.4200
180103	19.8965	20.3490	20.9598	20.3951
180104	18.9281	19.3922	20.2731	19.5382
180105	15.2394	16.6997	18.2976	16.6579
180106	14.3505	15.2895	15.5278	15.0462
180108	14.8187	14.4740	14.8720	14.7266
180115	16.7003	16.9096	18.0951	17.2235
180116	18.0392	18.6077	19.2389	18.6152
180117	17.7857	23.0192	20.7961	20.3977
180118	15.8597	16.9250	17.9017	16.8657
180120	16.1591	15.3115	16.4226	15.9318
180121	15.0983	20.0494	16.9570	17.2427
180122	18.5094	18.1930	18.7549	18.4922
180123	21.0613	21.1067	21.5962	21.2566
180124	17.4994	18.8487	19.7138	18.6761
180125	19.6416	14.9314	22.6609	18.1936
180126	12.9228	14.3551	14.8501	14.0804
180127	19.2581	17.6365	18.0498	18.2667

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
180128	17.6385	18.2817	18.7194	18.2299
180129	16.8378	22.3536	15.6637	17.9690
180130	19.8192	20.6450	21.9413	20.8049
180132	17.7744	19.5884	19.8393	19.0473
180133	21.6794	21.7800	23.2679	22.2101
180134	13.1935	14.5387	16.5901	14.7149
180136	17.3542	*	*	17.3542
180138	19.3692	20.2102	19.8524	19.8198
180139	18.7198	20.5350	20.3816	19.9038
180140	16.8152	15.2719	14.6466	15.5892
180141	20.9820	23.8930	20.3404	21.5800
180142	*	20.7510	*	20.7510
180143	*	*	21.3197	21.3196
190001	17.6832	18.1514	18.8583	18.2414
190002	19.1924	19.8834	20.6057	19.8935
190003	19.7749	19.9121	19.5115	19.7281
190004	17.7710	18.3620	19.6755	18.6227
190005	17.2422	17.5161	19.0994	17.9657
190006	17.8036	17.5911	17.7333	17.7115
190007	13.8189	14.4720	16.3633	14.9284
190008	18.6664	19.2456	22.4797	20.0804
190009	15.3555	15.9731	16.0395	15.7936
190010	16.2805	16.5020	17.7616	16.8604
190011	15.9534	15.6351	15.7319	15.7701
190013	16.8181	15.5019	16.7770	16.3476
190014	17.0959	17.8015	18.6929	17.8513
190015	18.6266	18.9896	19.7673	19.1223
190017	16.2393	17.5381	19.8449	17.8836
190018	15.0668	11.1898	13.1355	13.0348
190019	18.5257	18.3788	18.7344	18.5489
190020	17.5256	17.6840	18.7252	17.9732
190025	18.6369	16.8686	18.1892	17.9111
190026	18.1622	18.5015	19.0130	18.5687
190027	17.0827	17.4761	18.4070	17.6430
190029	16.5239	19.1967	18.7344	18.0923
190034	16.8503	18.0754	19.2007	18.0146
190036	20.1780	20.0300	21.2960	20.4842
190037	17.6945	19.9878	14.1323	17.4581
190039	19.4713	19.0376	18.7625	19.0694
190040	21.4634	21.7376	23.1819	22.1190
190041	17.6646	17.9535	19.5511	18.4761
190043	15.5580	15.5618	15.5645	15.5614
190044	17.2892	17.4471	17.6788	17.4765
190045	21.6107	21.2853	22.0065	21.6574
190046	19.7964	20.4458	20.2414	20.1666
190048	16.6683	16.8136	16.6848	16.7218
190049	17.2280	17.7417	18.5902	17.8611
190050	16.1980	16.2854	16.9053	16.4718
190053	13.2159	13.0080	13.4768	13.2412
190054	19.1738	18.9059	17.7269	18.6351
190059	15.6942	15.8373	17.8651	16.5018
190060	14.7186	17.8443	19.9121	17.2297
190064	20.4482	18.2466	19.7215	19.4539
190065	20.9927	18.3091	18.3280	19.0851
190071	14.4827	16.4138	16.3822	15.7772
190077	15.7805	16.5536	16.8829	16.4072
190078	14.8826	16.9383	19.5879	16.9873
190079	17.7120	17.9403	18.8187	18.1527
190081	15.3198	14.9707	14.7919	15.0273
190083	18.8895	18.4951	16.2970	17.9487
190086	15.8694	16.5074	17.6237	16.6689
190088	20.5531	19.9362	20.4725	20.3095
190089	13.0503	15.0395	15.2055	14.4221
190090	16.6664	16.2351	19.8201	17.5803
190095	16.2287	17.3258	17.3637	16.9543
190098	20.4897	21.0847	21.4328	20.9915

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
190099	19.9018	19.0635	19.0545	19.3385
190102	20.0300	20.7870	21.1614	20.6813
190103	12.1389	14.4158	15.6415	14.0050
190106	18.5813	18.5908	19.9117	19.0267
190109	15.5767	15.8187	16.3641	15.9327
190110	15.8052	15.7313	15.2652	15.5956
190111	19.7514	20.6508	21.3622	20.6278
190112	21.0232	22.0741	24.2806	22.3499
190113	12.5777	*	19.0411	16.0667
190114	12.6366	13.9209	13.5044	13.3578
190115	20.2473	22.7583	24.0098	22.2695
190116	15.5481	17.3757	18.3223	17.0452
190118	14.7876	16.3776	17.8543	16.2736
190120	13.9591	17.2309	17.6708	16.2867
190122	15.4793	15.3742	16.7189	15.8764
190124	20.6222	20.1206	22.8245	21.2142
190125	20.4517	19.8298	20.1401	20.1511
190128	20.4688	20.8770	21.5869	21.0028
190130	15.1467	14.0379	14.5586	14.5812
190131	20.7565	18.8958	19.7483	19.8133
190133	13.5383	15.1393	15.7834	14.7342
190134	12.1749	12.4507	*	12.3182
190135	21.6875	21.3454	23.0213	22.0078
190136	12.4091	15.1662	15.6286	14.4513
190140	14.2256	14.6829	14.8738	14.5954
190142	15.4861	16.2280	19.0464	16.8845
190144	16.2068	18.4405	18.3513	17.6419
190145	15.2345	16.2505	16.4402	15.9754
190146	21.2825	21.9607	20.9312	21.3917
190147	14.4345	14.7202	15.2732	14.8106
190148	16.6337	15.5338	19.4518	17.1031
190149	17.5997	16.4722	16.5153	16.8165
190151	14.7333	15.5210	16.2783	15.5127
190152	22.2070	22.0319	22.7142	22.3160
190156	15.7478	16.0442	17.6573	16.4812
190158	20.4637	20.4078	21.6307	20.8104
190160	17.1003	18.4662	19.3139	18.3349
190161	15.5737	15.9280	15.7807	15.7581
190162	20.6143	20.1962	20.9645	20.5966
190164	15.1783	18.2379	19.0473	17.3930
190167	16.6681	17.7611	15.5795	16.5709
190170	14.1750	14.5222	16.2045	15.0173
190173	23.6398	23.0934	*	23.4298
190175	19.3625	20.4580	23.0144	20.9805
190176	24.0574	22.2316	21.7051	22.5987
190177	18.6715	19.7794	20.3679	19.5997
190178	11.0657	12.0372	*	11.5413
190182	20.2855	20.7102	23.1997	21.3232
190183	16.7671	16.0752	16.7402	16.5275
190184	17.2044	19.8436	18.6583	18.5582
190185	20.1444	20.5852	20.7351	20.4997
190186	18.7568	17.4078	16.7272	17.7093
190190	17.4642	15.8985	13.7951	15.8564
190191	20.4975	19.6911	19.7218	19.9785
190196	17.9225	18.6138	19.1961	18.6202
190197	19.5569	20.2082	20.9871	20.3042
190199	16.0637	15.3522	17.8288	16.5088
190200	22.0391	21.6852	22.3510	22.0311
190201	18.7079	19.7421	21.7185	20.0957
190202	*	*	22.4701	22.4701
190203	21.7350	21.7931	23.0636	22.1708
190204	21.4624	20.5784	22.9134	21.6176
190205	19.6587	19.3737	18.8750	19.3122
190206	21.7012	21.3307	21.7867	21.6067
190207	20.5082	19.0216	20.7024	20.0851
190208	20.0065	16.9641	17.6834	18.1192

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
190218	19.7518	19.2992	20.7290	19.9128
190231	15.8287	17.7247	*	16.7208
190236	19.3395	21.1982	22.5796	21.1124
190238	*	20.6799	*	20.6799
190239	*	19.7601	*	19.7601
190240	*	14.3579	16.0658	15.2775
200001	18.0527	18.2513	19.7903	18.7081
200002	19.3629	22.3035	22.3145	21.3548
200003	16.9566	18.4141	18.5779	17.9947
200006	17.6586	21.0922	18.9818	19.2222
200007	18.7992	18.1681	19.0387	18.6537
200008	21.7489	21.5556	23.2883	22.2282
200009	22.2280	21.4763	23.3090	22.3517
200012	18.3484	19.1047	20.5141	19.3396
200013	18.0566	17.9378	20.3793	18.8704
200016	18.0866	17.1187	16.2939	17.1580
200017	17.2930	*	*	17.2930
200018	18.5397	17.8675	19.8848	18.7682
200019	19.2348	19.9245	21.1893	20.1239
200020	22.4526	22.3355	24.7433	23.2161
200021	19.9133	20.7361	22.0144	20.8877
200023	16.1707	20.2063	*	18.0379
200024	19.4329	20.8336	21.0633	20.4533
200025	20.2259	20.4165	21.4247	20.7140
200026	18.1194	17.9021	18.1459	18.0573
200027	18.5659	19.4220	20.2100	19.4300
200028	19.5708	18.8763	19.8886	19.4531
200031	16.2217	16.1641	17.7875	16.7057
200032	18.9315	19.4613	20.9148	19.7712
200033	21.8634	22.4685	23.6298	22.6316
200034	20.1519	20.4941	21.8266	20.8418
200037	18.6713	20.3015	19.5004	19.5071
200038	23.3851	21.2632	22.9220	22.5107
200039	19.8589	20.1508	21.5695	20.5351
200040	19.5503	18.9580	20.7744	19.7656
200041	19.3563	18.8131	20.2986	19.5168
200043	16.7224	19.4295	20.0280	18.6069
200050	20.1214	20.2014	23.0314	21.0760
200051	22.1525	22.0712	*	22.1031
200052	17.2099	17.6271	18.9290	17.9376
200055	18.8422	18.5983	19.4998	18.9700
200062	17.2273	18.4279	18.0949	17.9025
200063	19.9331	21.2121	22.5265	21.2349
200066	17.0289	17.0570	18.4281	17.5199
210001	20.4841	18.6617	21.5280	20.1745
210002	19.9219	23.5132	26.5907	23.2386
210003	20.3446	26.0447	22.3090	22.6337
210004	24.2909	24.9760	27.2278	25.4898
210005	21.4929	21.3829	22.5304	21.8195
210006	18.9436	19.3682	20.8607	19.7283
210007	23.1007	23.8840	23.4582	23.4837
210008	21.1768	21.2895	21.0767	21.1826
210009	20.5447	20.7479	20.8476	20.7179
210010	18.7197	19.5908	20.4097	19.6002
210011	21.4862	21.4043	20.4017	21.0852
210012	20.7203	21.3977	24.8430	22.2484
210013	19.7288	19.4505	23.1649	20.7921
210015	16.1912	18.7448	23.9651	19.4078
210016	23.8739	26.5193	24.7441	25.0180
210017	18.8928	18.5079	18.2963	18.5724
210018	22.2135	22.8553	23.6442	22.8975
210019	19.3046	20.6025	21.5429	20.4724
210022	22.6389	24.5744	25.6728	24.3137
210023	23.1950	22.9989	24.4815	23.5799
210024	20.6011	24.4280	24.7858	23.2181
210025	19.5876	21.2769	21.4910	20.6428

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
210026	12.1348	13.8668	20.7986	14.8993
210027	17.6855	17.1060	16.2219	17.0429
210028	19.6408	19.4157	20.4027	19.8293
210029	21.2167	25.4939	24.7605	23.8903
210030	21.7403	20.9574	21.9547	21.5644
210031	16.2299	*	*	16.2299
210032	17.7228	20.1955	20.0825	19.3625
210033	20.8053	23.7588	22.8303	22.4103
210034	15.7322	19.4144	22.6812	19.1023
210035	20.2731	20.8317	21.6662	20.9231
210037	18.3072	20.5528	21.1659	20.0571
210038	23.4971	24.9762	25.9701	24.7755
210039	19.9901	21.3559	23.3583	21.5884
210040	21.5014	23.4252	23.7067	22.8761
210043	19.6474	22.4000	22.9504	21.5561
210044	22.5781	23.0917	22.9540	22.8695
210045	11.6086	12.1467	13.5654	12.4021
210048	23.0537	24.6921	24.9381	24.2387
210049	19.0821	19.3022	21.1056	19.8459
210051	22.4335	23.6476	24.8949	23.6510
210054	22.3559	23.2730	25.1694	23.5831
210055	29.2539	26.5272	23.8025	26.3168
210056	19.2662	22.9593	22.6958	21.6241
210057	23.8289	26.0076	25.6142	25.1342
210058	22.0753	16.3191	17.4250	18.5418
210059	22.6766	25.6052	*	23.8855
210060	*	26.5846	26.4566	26.5245
210061	17.2240	16.1931	20.8975	18.1853
220001	21.9369	22.9064	23.4091	22.7509
220002	24.1285	24.5840	25.4158	24.6800
220003	16.9246	17.9319	17.6069	17.4814
220006	22.3085	22.6337	23.8920	22.9367
220008	24.4691	22.0796	24.2393	23.5663
220010	21.8582	22.0067	23.4009	22.4195
220011	26.1827	29.5290	20.6390	24.9566
220012	32.0829	31.2303	31.1041	31.4572
220015	22.5773	23.1893	24.1348	23.2890
220016	23.3750	23.0951	24.6149	23.6876
220017	22.4605	25.1568	25.9000	24.3877
220019	19.5613	19.8551	19.9268	19.7870
220020	21.4152	22.4295	22.5375	22.1352
220023	16.1885	*	*	16.1885
220024	21.5363	21.9316	23.8620	22.4506
220025	20.7882	22.8593	22.0003	21.8657
220028	22.8036	21.0630	24.1251	22.5899
220029	23.1509	25.6560	25.7660	24.8229
220030	18.5441	18.7429	18.9012	18.7275
220031	30.2430	29.3091	28.3832	29.0231
220033	20.0695	20.3609	21.8156	20.7051
220035	21.6396	23.1892	25.7456	23.4375
220036	24.6470	24.4091	25.5771	24.8579
220038	22.6518	22.3162	22.9821	22.6455
220041	23.4720	27.5034	28.6790	26.4083
220042	25.0779	26.0473	28.4675	26.3871
220046	22.7068	23.3149	24.1931	23.3833
220049	26.0025	27.2689	25.4358	26.2086
220050	22.0144	22.5265	23.3330	22.6222
220051	21.1033	21.7357	22.4826	21.7398
220052	23.7650	23.5225	25.4091	24.2083
220053	19.1280	*	*	19.1280
220055	21.3743	*	*	21.3743
220057	25.3902	25.8064	26.2945	25.8083
220058	19.9369	26.8345	21.6814	22.7654
220060	28.0843	28.0794	28.3950	28.1907
220062	20.4685	20.2254	22.5567	21.0855
220063	20.3951	20.8079	21.8365	21.0404

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
220064	22.3260	22.7497	24.0982	22.9997
220065	20.1364	20.1424	21.5657	20.6303
220066	20.7826	23.4477	24.5463	22.8901
220067	26.4443	27.5405	28.2685	27.3486
220070	19.7528	20.9128	23.9850	21.5896
220071	25.6184	27.4151	27.7679	26.9213
220073	25.6025	26.1328	27.4778	26.3977
220074	25.6390	24.3057	25.3331	25.0103
220075	22.8057	22.5329	24.6982	23.3522
220076	22.6668	23.2795	24.1224	23.3492
220077	25.2646	26.1545	27.1503	26.1736
220079	22.6256	22.0769	25.7305	22.9418
220080	21.5238	22.1971	22.9911	22.2508
220081	29.1726	29.6682	31.1326	30.0117
220082	21.6726	22.1453	23.2818	22.3672
220083	23.9156	22.5815	27.2605	24.4264
220084	23.6641	25.3761	26.0395	25.0431
220086	23.8705	26.7778	28.7324	26.2982
220088	22.9067	23.4258	25.0671	23.8081
220089	23.0965	25.4106	25.3521	24.5662
220090	22.0041	23.3049	26.0265	23.7769
220092	18.5239	24.7905	29.4173	22.0343
220095	21.4831	21.7851	22.6828	21.9956
220098	21.5906	23.1547	24.7180	23.1447
220100	25.7077	27.5841	26.8001	26.6854
220101	25.9204	27.0711	28.0856	27.0037
220104	28.0021	28.7258	*	28.3658
220105	21.4129	21.9185	25.5692	23.0562
220106	25.6577	25.9277	27.6812	26.4594
220108	21.9115	23.4975	24.5939	23.3257
220110	28.7071	29.1648	30.6173	29.5024
220111	23.8066	24.7510	26.7573	25.1031
220116	26.1662	32.0049	28.5716	28.7434
220119	23.3216	23.8785	24.6344	23.9280
220123	25.8994	32.4678	29.6084	29.3682
220126	22.5218	23.6045	23.8123	23.3172
220133	25.4596	29.3911	29.8366	28.1948
220135	25.6522	28.3648	29.6837	27.9677
220153	22.9592	*	*	22.9592
220154	22.4770	21.1563	23.3590	22.3695
220163	29.1143	29.2299	29.3552	29.2328
220171	24.5553	24.9261	27.3487	25.7067
230001	19.8020	20.0438	23.3051	20.9963
230002	22.7991	23.0439	24.3115	23.3442
230003	19.8420	21.2215	21.6493	20.9088
230004	23.1036	20.5005	22.4538	21.9617
230005	18.5644	17.0943	20.5596	18.6769
230006	19.1041	20.4978	20.6985	20.0828
230007	15.5538	*	*	15.5538
230012	15.0803	*	*	15.0803
230013	20.8018	22.2211	20.0954	21.0266
230015	20.1104	20.6464	21.9499	20.8811
230017	22.2822	22.9755	25.7900	23.6501
230019	22.2622	23.6674	23.8779	23.3381
230020	22.1280	21.8526	28.8869	23.8899
230021	18.9636	19.8256	20.9145	19.9553
230022	18.8006	21.9129	21.8808	20.8639
230024	23.7326	24.9664	26.2155	24.8592
230027	14.6950	19.6393	22.5114	18.5396
230029	19.4911	22.1782	24.9754	22.1623
230030	18.3916	18.6406	19.2441	18.7650
230031	19.3162	19.9465	19.4676	19.5690
230032	21.8845	24.8930	22.8436	23.1984
230034	19.0473	19.4366	17.9276	18.7511
230035	17.5109	17.7490	20.5906	18.5317
230036	23.2119	23.8398	25.1507	24.0919

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
230037	20.4747	23.2751	22.7382	22.1469
230038	23.5251	21.9692	20.9389	22.1189
230040	21.4393	20.7841	20.2451	20.8039
230041	20.3131	21.7364	23.2870	21.7251
230042	22.1043	21.3870	20.7745	21.4261
230046	25.5696	25.3206	26.1787	25.6837
230047	21.5381	22.3595	23.7178	22.5293
230053	25.4968	26.8917	23.5702	25.3801
230054	20.6963	20.8014	22.2105	21.1829
230055	20.7932	20.8492	20.8930	20.8452
230056	16.0766	17.8091	17.3516	17.0331
230058	20.4165	21.0303	21.6619	21.0335
230059	19.9240	20.7092	20.6540	20.4211
230060	19.8021	19.8987	20.5120	20.0740
230062	17.1540	18.8039	18.2283	18.0500
230063	20.4171	*	*	20.4171
230065	22.3459	22.7416	23.3414	22.8607
230066	22.1768	23.0475	23.2790	22.8376
230069	23.2076	24.2470	25.0212	24.1384
230070	20.2505	21.5666	21.2476	21.1404
230071	22.9052	23.1337	23.6398	23.2244
230072	20.6944	20.4456	22.6533	21.2484
230075	20.0545	22.5866	22.3632	21.5991
230076	24.4547	24.7010	26.9662	25.2705
230077	21.0178	20.2823	22.6781	21.3201
230078	17.5577	17.9868	19.1638	18.2565
230080	19.7687	20.2104	19.1810	19.7086
230081	19.0345	19.0199	20.0464	19.3283
230082	18.2992	19.0419	18.2165	18.5095
230085	20.2096	23.4996	24.5765	22.7898
230086	18.9420	20.1730	20.1461	19.7538
230087	18.9034	19.9700	20.6619	19.7714
230089	23.9100	22.6994	23.1023	23.1968
230092	20.0145	20.7738	22.3437	21.0873
230093	20.4655	20.6314	21.0274	20.7091
230095	17.3313	17.6444	18.0582	17.6864
230096	22.8410	22.7785	24.3004	23.2947
230097	21.2854	21.1254	22.5006	21.6504
230099	21.1933	21.7513	22.3422	21.7796
230100	17.1336	17.3842	18.2477	17.5807
230101	20.0932	20.5315	22.5159	20.9964
230103	22.7696	11.3429	18.5254	17.4039
230104	23.1457	24.1238	25.5606	24.3812
230105	21.5210	22.6098	23.0086	22.4180
230106	20.7997	21.6825	22.9909	21.8109
230107	16.5966	17.1386	18.9985	17.6147
230108	18.8631	20.3437	21.4592	20.2385
230110	18.9825	19.7262	21.0925	19.9233
230113	14.9411	*	*	14.9410
230115	18.4050	19.6281	21.0361	19.6522
230116	16.5419	14.5692	15.6064	15.5368
230117	25.9318	25.6797	25.5154	25.7018
230118	21.3028	20.6797	20.2770	20.7229
230119	21.1918	22.6555	23.9898	22.6112
230120	18.5264	20.3306	20.6105	19.6370
230121	20.3158	21.3342	21.4615	21.0465
230122	20.9078	*	*	20.9078
230124	20.3608	18.9981	20.9641	20.0945
230128	24.9081	24.0724	24.4952	24.4850
230130	23.5170	22.1775	23.5123	23.0660
230132	26.6386	26.1946	27.3637	26.7267
230133	17.6894	17.1058	19.0770	17.9441
230135	22.5258	20.5637	18.4193	20.8744
230137	19.1813	*	*	19.1813
230141	22.1299	22.4570	24.4560	22.9910
230142	22.2940	23.5621	25.0282	23.5411

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
230143	16.3043	16.7948	18.2700	17.1074
230144	22.1108	23.4237	23.3295	22.9371
230145	20.2542	19.2638	17.9811	19.0315
230146	20.5044	21.2260	22.3838	21.3821
230147	21.8496	23.2755	26.5260	23.6730
230149	20.7691	18.8005	19.9577	19.8029
230151	22.1713	23.3967	24.3705	23.2857
230153	19.5633	18.7403	20.0098	19.4472
230154	15.4456	15.4362	16.7152	15.8739
230155	17.2076	20.5409	20.7546	19.4417
230156	24.7587	25.6228	27.2254	25.8423
230157	20.3667	17.3571	*	18.9586
230159	20.0749	*	*	20.0749
230162	21.4636	21.7148	22.7984	21.9769
230165	23.0106	23.8881	24.7959	23.8782
230167	21.5048	22.9745	24.1344	22.8771
230169	23.0652	24.3874	28.1039	25.0117
230171	13.3863	17.1282	16.1129	15.4610
230172	20.6417	21.4675	22.1709	21.4477
230174	23.0272	22.7304	23.5025	23.0851
230175	16.8909	*	14.4932	15.4643
230176	22.7772	23.8204	24.9032	23.8211
230178	16.9156	17.3030	17.3428	17.1968
230180	15.8769	18.5744	19.6062	17.9856
230184	19.0604	19.7717	20.6406	19.8113
230186	19.5337	15.7837	19.1289	18.1131
230188	15.7112	16.2975	16.8687	16.3031
230189	16.6838	17.9218	19.1990	17.9352
230190	26.8196	26.4687	24.4643	25.9234
230191	19.0013	18.4861	20.6633	19.3446
230193	19.7066	19.8287	21.5358	20.3443
230195	21.7775	22.9228	23.4647	22.7456
230197	24.0184	24.0854	25.5312	24.5187
230199	19.4451	20.6580	22.4592	20.8791
230201	17.2141	18.0787	18.2486	17.8664
230204	25.4181	23.4966	24.5127	24.4525
230205	14.3788	15.9314	18.1551	16.1081
230207	20.6375	21.2483	20.9059	20.9181
230208	16.0733	16.7454	17.8118	16.8684
230211	18.6744	21.8581	21.1245	20.4277
230212	23.3021	24.2611	24.6420	24.0563
230213	15.1908	15.5469	17.1062	15.9226
230216	20.3359	21.0710	22.2137	21.1969
230217	21.2707	22.2698	24.1455	22.5496
230219	19.1549	20.0442	18.1277	19.1400
230222	22.1785	21.9711	23.2545	22.4802
230223	21.1528	22.6887	25.2666	22.9884
230227	23.7259	22.3155	25.8826	23.9496
230230	22.2385	22.3097	22.1703	22.2333
230235	16.8684	17.7197	17.5940	17.3919
230236	24.3835	25.9676	25.3251	25.2517
230239	18.0942	17.8168	18.9790	18.2974
230241	19.1000	20.7297	21.8472	20.5923
230244	21.7413	22.2697	23.1175	22.3742
230253	20.5945	21.0433	22.7706	21.4304
230254	21.9402	22.6335	23.3714	22.6370
230257	19.6982	21.3880	23.1794	21.3083
230259	22.2393	22.3969	23.1768	22.6077
230264	17.1319	17.4864	18.6598	17.7284
230269	23.3105	24.0992	24.3772	23.9435
230270	22.6187	22.5985	25.2665	23.4475
230273	22.9199	22.8715	24.1278	23.2898
230275	17.7487	20.8985	32.0037	21.0819
230276	21.3722	25.8709	22.3313	22.8959
230277	23.1456	23.9771	24.3351	23.8587
230278	18.2110	*	*	18.2110

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
230279	17.6973	17.8074	18.3256	17.9471
230280	15.6654	18.3497	*	16.7057
230283	27.9480	22.5082	*	24.9202
230286	*	*	47.5925	47.5929
230287	*	*	22.5420	22.5420
240001	24.6207	25.6936	26.6372	25.6759
240002	22.7981	23.2307	24.2214	23.4301
240004	25.1908	24.4030	25.6238	25.0604
240005	17.9563	20.3193	20.2389	19.4808
240006	25.1602	23.0715	25.7288	24.6342
240007	17.7625	19.0850	20.7189	19.1593
240008	20.2158	23.3783	22.7437	21.9832
240009	16.8965	17.1187	17.4518	17.1699
240010	23.6477	25.4752	28.3796	25.8852
240011	20.5192	21.5875	22.5188	21.5240
240013	20.3282	21.7544	25.1560	22.2201
240014	23.0025	24.2610	25.2306	24.1808
240016	20.4017	22.2011	23.3772	21.9959
240017	18.3585	18.9272	19.3431	18.8677
240018	20.8501	18.4268	23.6092	20.7339
240019	22.1501	23.1477	24.0613	23.1411
240020	21.1937	20.8849	20.6819	20.9116
240021	18.7515	20.1457	19.0469	19.2586
240022	21.7889	21.3234	23.0394	22.0529
240023	21.5087	22.8224	22.3002	22.1691
240025	18.8345	20.0308	20.7672	19.8809
240027	19.1017	16.7758	18.3837	18.0732
240028	19.7918	25.1934	*	22.5025
240029	21.1329	20.0164	23.0440	21.3549
240030	18.8547	20.1653	20.9799	20.0254
240031	18.1566	19.3983	21.7620	19.6652
240036	22.2460	22.1721	22.5436	22.3299
240037	19.2345	20.1195	21.4275	20.2550
240038	25.3061	24.3957	26.4513	25.4092
240040	20.4813	23.1352	22.8191	22.1112
240041	19.2864	21.8655	21.9054	20.9373
240043	17.7335	16.9859	18.0186	17.5712
240044	18.8411	20.3339	22.5750	20.4995
240045	21.1396	24.1557	24.2936	23.2125
240047	22.6152	23.8098	25.3233	23.8993
240050	25.2983	21.6499	23.1109	22.6766
240051	19.9195	22.5855	23.2612	21.9129
240052	20.7749	*	22.3485	21.5706
240053	22.9611	23.8693	24.4191	23.8099
240056	23.4226	23.7139	24.8549	24.0398
240057	24.2159	24.8686	25.3984	24.8617
240058	14.9697	18.4009	19.0506	17.2677
240059	23.6215	23.7808	25.3847	24.2488
240061	27.2603	25.9951	27.9151	27.0571
240063	23.7866	24.4031	25.8594	24.6824
240064	23.2860	22.8578	24.6785	23.6296
240065	12.7867	14.8734	14.4623	14.0357
240066	23.0698	24.1143	25.5163	24.2946
240069	19.8282	21.7991	23.3373	21.6146
240071	20.2101	21.2463	22.6332	21.3841
240072	21.1824	20.9529	21.5455	21.2291
240073	16.0840	17.3559	17.9013	17.1144
240075	21.2654	21.3357	21.9160	21.5185
240076	21.8795	22.3280	23.6159	22.6457
240077	15.3794	20.3445	22.1509	19.1544
240078	23.9150	25.1082	26.2576	25.1181
240079	18.4338	18.8345	18.2929	18.5204
240080	24.3399	25.5619	26.3071	25.3922
240082	18.3555	18.7995	20.2018	19.1212
240083	19.7637	21.0317	22.3484	20.9968
240084	19.4739	21.7421	23.1951	21.4482

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
240085	22.5736	20.9778	20.7535	21.3852
240086	16.9392	18.1401	18.1497	17.7863
240087	18.8352	21.3323	21.2116	20.4135
240088	21.6858	23.1056	24.6260	23.0939
240089	20.7239	21.1989	21.3949	21.1104
240090	19.2968	19.2166	21.0856	19.8725
240093	18.7092	20.2400	20.7138	19.9194
240094	20.9446	22.0247	22.5923	21.8995
240096	20.1644	21.0417	20.2992	20.4825
240097	24.2662	27.9496	29.7597	27.1621
240098	21.3467	24.2296	23.9626	23.2314
240099	14.4649	15.4964	18.8139	15.9924
240100	20.8302	20.8325	24.1875	21.9081
240101	19.2120	19.9837	22.1329	20.4409
240102	14.6067	16.3659	15.5114	15.4871
240103	19.1540	18.7510	21.0182	19.5968
240104	23.2178	23.5351	25.1139	23.9642
240105	14.3965	*	*	14.3966
240106	23.5148	23.5005	23.9677	23.6780
240107	20.3983	20.9004	21.2163	20.8360
240108	15.3547	18.2427	17.6500	16.9347
240109	13.5537	16.3216	15.1369	14.9110
240110	19.4828	21.0277	21.7340	20.7301
240111	17.2100	17.8617	19.9712	18.3046
240112	15.8350	16.6244	17.2437	16.5628
240114	16.2505	17.3682	18.3415	17.5274
240115	23.7765	23.8675	24.6529	24.0991
240116	16.6731	18.3520	17.3460	17.3960
240117	18.0636	17.9941	18.6677	18.2608
240119	20.6126	21.8289	23.0230	21.7338
240121	23.4018	22.2266	22.4858	22.6970
240122	19.1811	21.2876	20.7795	20.4095
240123	16.5098	18.3941	18.9494	17.8731
240124	19.4400	20.4728	21.2023	20.3644
240125	12.3627	14.9708	17.3846	15.0136
240127	15.8966	17.9724	16.4294	16.7198
240128	17.2513	16.3608	17.5611	17.0478
240129	14.4212	16.5209	17.7242	16.1756
240130	14.9399	16.4271	17.7634	16.3549
240132	23.0669	23.1452	24.5633	23.6102
240133	19.2126	19.5293	20.8958	19.9049
240135	14.3069	15.7015	15.6298	15.1560
240137	20.3750	21.5073	21.6644	21.1797
240138	15.2062	16.7332	19.1676	16.8305
240139	20.8053	20.5496	21.0163	20.7883
240141	23.8066	23.1009	23.6498	23.5064
240142	25.2770	29.2238	24.0719	25.9878
240143	16.6172	20.4266	20.7307	19.0810
240144	18.2604	21.4469	23.1661	20.7059
240145	17.2778	19.0689	17.6747	18.0668
240146	16.0652	16.5412	17.3275	16.6788
240148	18.8779	19.5204	19.5372	19.2785
240150	13.8786	20.8331	23.3857	18.4647
240152	21.1678	22.4744	24.1818	22.6586
240153	16.5412	19.3336	18.6556	18.0746
240154	17.5769	21.5052	21.5859	20.1583
240155	19.8762	20.9385	23.6944	21.5112
240157	17.4168	13.7309	20.0571	17.0514
240160	15.9492	15.9014	16.4990	16.1163
240161	15.7996	16.8809	18.0542	16.8888
240162	16.6292	19.1542	19.3296	18.3301
240163	18.8320	20.4760	22.2009	20.3835
240166	17.3233	19.4131	19.4496	18.7799
240169	16.6725	16.3958	*	16.5195
240170	18.8762	20.3779	21.5994	20.2122
240171	17.2886	18.5172	19.6732	18.5083

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
240172	18.2852	20.8606	20.3699	19.7027
240173	17.2655	18.5187	18.3183	18.0300
240179	17.5116	20.4004	17.7557	18.4699
240184	15.3793	16.8917	17.6979	16.5493
240187	19.9230	21.2736	23.2471	21.4869
240193	17.8226	18.4664	26.6381	21.1834
240196	24.3472	25.3479	26.2793	25.3808
240200	14.3415	14.9076	18.7517	15.8336
240207	24.1127	25.2814	26.0927	25.2080
240210	24.2218	24.5664	25.6060	24.8336
240211	19.7399	30.6260	34.7849	25.7741
250001	18.4233	19.2756	20.2019	19.2920
250002	17.2501	18.6938	19.6081	18.5060
250003	17.6539	16.7570	18.7331	17.7215
250004	17.8868	18.3860	19.2913	18.5189
250005	12.5993	12.5834	13.7341	13.0041
250006	16.9048	17.5192	19.4531	17.9224
250007	19.2913	19.7562	20.9757	19.9959
250008	14.1760	15.8506	15.8096	15.2607
250009	18.5610	17.7283	18.0463	18.1158
250010	13.3905	14.6101	16.0233	14.5948
250012	14.1623	16.7579	17.4032	16.1420
250015	13.5274	11.7249	16.6522	13.7345
250017	17.9410	20.5976	18.8850	19.0991
250018	11.9311	13.1687	14.7291	13.0932
250019	16.7425	18.0956	19.9070	18.3382
250020	13.4476	16.2698	19.6575	16.1595
250021	9.4318	10.5844	12.7242	10.6438
250023	13.9116	12.3434	13.8210	13.3756
250024	12.7127	12.9899	14.8394	13.4135
250025	19.0390	20.3625	21.9075	20.5374
250027	14.9519	14.5445	15.1790	14.8945
250029	16.4834	16.0682	14.8216	15.7783
250030	17.3636	26.6173	25.5089	23.0726
250031	17.9715	18.3825	19.8779	19.1622
250032	17.1339	17.5957	*	17.3669
250033	17.8257	15.0941	16.9132	16.6524
250034	16.6988	17.0399	18.8231	17.5333
250035	15.2353	16.8349	18.3861	16.7093
250036	15.8445	16.1913	17.6247	16.6012
250037	15.4325	12.7156	14.3994	14.0734
250038	16.8454	17.7019	18.8434	17.7665
250039	14.1556	15.1409	16.4502	15.2329
250040	17.3430	18.3364	19.6513	18.4442
250042	16.3867	17.6531	18.3858	17.4884
250043	16.0729	16.6500	18.4025	16.9554
250044	16.1218	16.7321	19.0321	17.2885
250045	22.0839	21.8988	22.7225	22.2606
250047	13.3706	14.7461	16.0109	14.4887
250048	16.8932	17.6649	19.4976	18.0474
250049	11.6715	12.1635	12.8275	12.2266
250050	14.3949	15.1159	16.0234	15.1991
250051	9.3464	10.4900	10.1212	9.9666
250057	15.9237	16.1838	16.6316	16.2556
250058	15.5327	15.7197	16.2623	15.8399
250059	16.2845	16.6494	17.9507	16.9440
250060	13.0301	16.1804	12.6893	13.8440
250061	11.0308	11.5108	12.0186	11.5214
250063	13.2540	13.3092	15.0894	13.8432
250065	12.8853	13.6904	15.0507	13.8065
250066	15.6760	16.1742	17.2711	16.3375
250067	16.4120	16.8522	18.3773	17.2393
250068	13.6768	13.4127	13.2644	13.4415
250069	17.8960	16.8980	18.5782	17.7677
250071	14.3781	12.3488	13.1934	13.2742
250072	18.2218	18.9487	21.0602	19.2655

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
250076	10.5098	*	*	10.5097
250077	12.2564	13.7404	13.9479	13.2870
250078	15.6336	15.9739	17.4118	16.3692
250079	16.2712	16.5835	16.1483	16.3337
250081	17.3325	19.0358	18.1848	18.1653
250082	16.0975	17.1427	17.3096	16.8599
250083	14.2634	16.6065	16.3054	15.6454
250084	17.0189	20.6429	21.0870	19.3827
250085	14.3797	15.4477	16.7377	15.5314
250088	17.8674	18.2736	19.3976	18.4880
250089	13.4238	14.3027	15.0238	14.2301
250093	15.2044	16.1506	16.8647	16.0778
250094	18.0852	18.5063	18.9681	18.5063
250095	17.0039	17.4217	18.4944	17.6334
250096	19.0688	19.0584	19.3630	19.1609
250097	16.9905	15.5741	16.3328	16.3172
250098	13.1341	18.3874	18.8163	16.4425
250099	14.8528	15.1265	15.9867	15.3437
250100	17.1682	17.8688	19.7559	18.3193
250101	18.4685	17.7194	17.6704	17.9924
250102	23.9329	18.9348	19.8487	20.8096
250104	18.2502	18.7651	19.0165	18.6823
250105	14.5401	15.5133	16.1480	15.4020
250107	15.1496	15.0737	16.5635	15.5581
250109	22.1551	21.3867	24.5760	22.6981
250112	15.5610	16.3640	16.6447	16.1593
250117	16.1225	16.9787	15.9335	16.3432
250119	15.2199	16.1218	16.5700	15.9756
250120	15.3433	16.7182	18.1428	16.6322
250122	18.9417	19.2990	19.8033	19.3541
250123	18.8690	18.7863	22.1376	19.9106
250124	13.1823	13.2490	14.4008	13.6109
250125	20.8895	21.2660	21.9366	21.3768
250126	18.2355	21.9101	19.0168	19.6297
250128	14.0048	16.1418	15.9958	15.4423
250131	12.6056	12.4557	11.2470	12.0464
250134	17.0671	18.5142	21.4489	18.9054
250136	18.9689	21.3497	20.0333	20.0576
250138	18.4028	20.4550	19.3446	19.3211
250141	19.0113	19.6692	21.6835	20.2708
250145	10.2507	11.2120	11.2021	10.8489
250146	14.4924	14.7781	15.4061	14.8913
250148	18.0980	19.4233	23.1459	20.1203
250149	12.9569	15.2318	15.7537	14.6277
250150	*	21.8599	*	21.8600
260001	18.0971	20.1560	20.9620	19.7027
260002	22.1183	21.6597	23.4259	22.4118
260003	14.6553	15.4482	16.2023	15.4433
260004	13.0133	13.7035	15.2735	13.9164
260005	19.5554	23.9681	22.5860	22.0140
260006	19.7467	20.0994	22.1692	20.6408
260008	13.8495	16.8893	18.2114	15.8498
260009	18.5080	18.2863	19.0654	18.6237
260011	19.1027	19.5059	20.3279	19.6368
260012	14.3645	17.1662	17.3810	16.3363
260013	15.9884	16.1825	17.3772	16.4946
260015	16.5822	17.8817	18.3849	17.5418
260017	16.7916	16.9914	17.9796	17.2888
260018	12.0060	12.5301	13.6120	12.7676
260019	18.6113	*	18.3629	18.4928
260020	20.5142	20.2241	21.0314	20.5884
260021	22.1017	21.6237	23.3527	22.2918
260022	17.2462	17.7772	18.7707	17.9082
260023	16.4705	17.8649	18.5665	17.6119
260024	15.2356	15.7815	15.6095	15.5379
260025	15.4935	17.0965	18.2804	16.9786

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
260027	21.2977	22.0362	23.1505	22.1110
260029	19.7484	21.1858	20.1832	20.3332
260030	12.5118	11.9215	12.8349	12.4289
260031	19.4921	19.7249	22.5379	20.4276
260032	20.1988	19.6728	20.3847	20.0821
260034	17.4233	20.4902	20.5439	19.5050
260035	13.1065	13.0071	15.1611	13.8141
260036	16.7430	18.8104	20.1242	18.6072
260039	14.1866	14.6644	15.9689	14.9611
260040	17.3099	18.0140	18.5132	17.9641
260042	18.7567	18.7514	20.8821	19.5084
260044	15.9927	15.9206	16.7879	16.2332
260047	19.0112	19.2247	20.2724	19.4793
260048	20.0885	21.0602	22.4800	21.2299
260050	15.6908	16.8520	17.8142	16.7717
260052	18.0553	18.0914	19.1044	18.4413
260053	15.2236	16.5166	17.4110	16.3851
260054	20.0199	20.6242	23.0188	21.1083
260055	12.0118	15.4214	17.9547	14.9547
260057	17.4636	19.7144	16.5704	17.9947
260059	16.1000	17.0546	16.2074	16.4474
260061	14.7175	15.7112	17.1343	15.8685
260062	20.1477	21.3138	22.0091	21.1981
260063	18.2309	18.8973	19.7231	18.9234
260064	16.5934	17.8033	18.3749	17.5653
260065	19.4382	20.0975	20.6671	20.0563
260066	14.9640	15.3460	15.3139	15.2114
260067	14.2249	15.1837	14.5499	14.6334
260068	20.2418	19.4240	20.7947	20.1541
260070	*	13.9510	18.7384	16.1582
260073	14.2550	15.9182	16.9496	15.7508
260074	19.0350	19.8915	20.4033	19.8192
260077	18.6473	19.4482	20.5830	19.5877
260078	15.6381	14.9463	16.0586	15.5564
260079	14.2985	16.1453	16.4816	15.5347
260080	13.5384	14.6832	13.1617	13.7147
260081	21.0151	20.3053	20.2471	20.5212
260082	15.9407	15.9858	18.2853	16.7287
260085	20.4669	20.7051	21.5137	20.8993
260086	14.3164	15.2927	16.7579	15.4677
260091	19.9987	21.5464	22.0772	21.4012
260094	18.0085	18.5395	19.7308	18.8006
260095	19.6944	20.7292	21.6999	20.6994
260096	23.0282	22.5972	22.8259	22.8155
260097	16.5582	19.0632	18.6965	18.1123
260100	15.7047	16.6523	16.5439	16.3025
260102	20.1264	20.6361	21.2133	20.6454
260103	18.5957	19.7146	19.9144	19.3556
260104	21.0138	20.3176	21.6624	21.0040
260105	24.7223	24.8181	22.8005	24.0843
260107	19.8422	20.4269	22.5214	20.7581
260108	19.4609	20.0034	20.9029	20.1514
260109	13.9129	14.8181	15.9724	14.8936
260110	17.8375	18.3227	19.5633	18.5673
260113	14.6756	16.2223	16.1346	15.6436
260115	19.2259	17.4698	19.3873	18.6920
260116	16.2774	14.9812	16.0187	15.7314
260119	16.8836	17.2942	18.0725	17.4218
260120	16.3755	16.4904	17.6811	16.8504
260122	14.9697	16.0931	16.3700	15.8295
260123	14.6444	14.6822	15.2926	14.8761
260127	18.3572	18.4026	18.1342	18.2957
260128	13.0481	12.6414	13.2942	12.9961
260131	17.7686	18.4154	18.0395	18.0595
260134	16.2832	17.5127	17.1341	16.9643
260137	17.9531	19.4697	19.5976	19.0342

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
260138	22.6491	23.2364	23.6502	23.1620
260141	19.1580	19.1893	19.0444	19.1314
260142	17.1248	17.3084	18.2023	17.5590
260143	12.7867	13.9040	15.4688	13.9600
260147	14.0778	14.7769	15.8522	14.8908
260148	11.8674	11.3524	12.6651	11.9425
260158	12.3005	12.7699	13.9790	13.0499
260159	20.3177	19.7951	20.9636	20.3519
260160	15.8394	16.5792	18.4007	16.9325
260162	19.5655	21.4099	20.7331	20.5870
260163	16.4245	15.8593	16.8300	16.3731
260164	14.9372	15.1211	16.3874	15.4903
260166	20.1025	21.1224	22.4071	21.2079
260172	15.4163	16.0772	16.4854	15.9816
260173	12.8523	14.2090	15.5733	14.3947
260175	16.9023	17.5625	18.3632	17.6144
260176	26.8712	21.6044	23.2414	23.9990
260177	21.2578	21.9014	22.9112	22.0696
260178	19.6638	20.2796	20.8189	20.2016
260179	21.4906	22.7185	21.4470	21.8753
260180	19.5819	18.9881	19.5983	19.3863
260183	20.0712	21.3175	23.7057	21.6731
260186	19.3238	19.6026	21.0675	20.0580
260188	20.6388	22.5060	23.7475	22.1881
260189	11.3004	16.4233	*	13.8239
260190	18.5168	19.3419	21.6994	19.8001
260191	17.9812	18.1604	19.6784	18.6471
260193	21.1588	20.2577	22.2030	21.2172
260195	17.7237	19.7068	*	18.7154
260197	19.2840	20.5453	*	19.7846
260198	11.9751	19.7552	21.7926	16.7576
260200	20.5339	20.6888	21.7031	21.0210
260205	17.6210	*	*	17.6210
270002	28.9959	19.2387	19.0221	21.4738
270003	22.0995	22.5019	20.7277	21.7202
270004	19.6292	19.4834	20.1821	19.8074
270006	16.0238	17.0715	15.1006	15.9252
270007	11.3143	13.8824	15.5780	13.1858
270009	17.2292	20.8238	20.7031	19.5097
270011	20.2669	21.1653	21.8086	21.0508
270012	19.7346	19.7878	20.7913	20.0975
270014	19.0872	19.9859	20.4321	19.8518
270016	19.6717	18.6149	17.9984	18.9093
270017	21.0800	20.0152	22.1046	21.0660
270019	18.1099	15.4128	18.5111	17.2358
270021	17.1787	16.9457	18.0515	17.3782
270023	22.2639	22.7181	22.7162	22.5721
270026	17.5102	18.0568	20.1673	18.5919
270027	13.1392	17.2091	17.2005	15.5928
270028	21.1492	19.1177	19.6212	19.9204
270029	16.5666	17.3710	18.2097	17.3728
270032	17.7393	18.7811	19.3937	18.6694
270033	16.9602	18.4876	20.7060	18.6303
270035	16.8295	16.4302	17.9822	17.0833
270036	14.2537	16.8552	16.1031	15.5470
270039	15.9368	19.6796	20.3800	18.4120
270040	18.8145	20.1242	20.1887	19.6792
270041	19.0327	25.8153	*	21.5554
270044	16.7710	17.5137	19.2939	17.7721
270048	17.0154	18.0666	17.4506	17.4823
270049	22.2444	22.2540	22.0263	22.1740
270050	16.7110	19.9356	19.6317	18.7001
270051	20.2735	20.1950	20.0386	20.1652
270052	14.4773	14.7009	17.1932	15.3511
270057	21.1317	20.6714	20.1507	20.6215
270058	14.7481	16.1412	18.4780	16.2593

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
270059	14.7530	19.1808	16.9303	16.8245
270060	15.2727	20.4148	21.3776	18.5305
270063	12.6108	15.1049	16.4553	14.5559
270073	14.4569	16.1937	16.6083	15.6741
270079	15.6873	16.7048	19.5493	17.1331
270080	16.3171	15.0705	16.6010	15.9696
270081	15.6262	16.7389	18.0543	16.7908
270082	17.3443	23.1245	23.3209	21.2882
270083	18.4432	17.8554	16.8420	17.6939
270084	16.6243	16.2958	15.7062	16.1694
280001	17.3541	18.1831	18.7137	18.0270
280003	22.3179	23.0213	23.6058	22.9865
280005	19.2405	23.6949	22.8981	22.0010
280009	19.8145	20.9643	23.2300	21.3319
280010	17.4859	20.0462	22.0137	19.0287
280011	15.8573	15.9614	16.2281	16.0212
280013	22.8063	22.5163	24.0852	23.1972
280014	15.9596	16.8368	16.7109	16.5080
280015	17.0281	16.6939	18.0207	17.2299
280017	14.2059	13.9939	16.9884	15.1266
280018	15.1328	15.4496	16.6439	15.7480
280020	19.9667	21.2467	21.9587	21.0976
280021	17.1048	17.6345	19.1263	17.9823
280022	16.7179	16.8184	15.3785	16.3083
280023	25.8494	22.3433	21.5761	23.0011
280024	14.2186	15.0380	15.8747	15.0019
280025	15.5850	21.4764	22.2214	19.5445
280026	16.6861	16.5851	18.7258	17.3340
280028	17.3176	18.0793	19.1080	18.1555
280029	23.1292	24.4359	17.1351	21.6012
280030	24.5366	24.7723	26.3542	25.1586
280031	13.5654	9.6321	9.6951	11.0351
280032	18.8964	19.1191	20.5246	19.5206
280033	15.7583	17.4745	17.9841	17.1215
280035	15.9170	16.6872	18.6089	16.9344
280037	16.7952	17.1064	14.8049	16.2282
280038	17.0878	18.2503	18.9305	18.0758
280039	16.0442	16.1587	17.0153	16.4148
280040	19.5333	20.9896	21.5426	20.7346
280041	16.4083	16.5503	16.6889	16.5558
280042	16.1191	16.6239	16.4684	16.3973
280043	16.6570	17.5937	16.8186	17.0314
280045	16.9048	15.7630	17.7408	16.7631
280046	17.9221	17.3214	17.9752	17.7358
280047	18.3407	17.4735	21.3143	18.9885
280048	15.8723	15.8100	17.9319	16.5389
280049	18.3605	18.4365	19.4589	18.7530
280050	16.6432	20.0379	*	18.4507
280051	15.6336	17.1942	19.6206	17.2054
280052	14.0819	14.1201	14.9903	14.4198
280054	18.7992	18.7575	19.4049	18.9732
280055	13.5667	13.8129	14.2046	13.8644
280056	12.6475	15.6135	15.6442	14.4971
280057	18.0454	20.0686	21.4754	19.8186
280058	19.6752	21.4868	22.8105	21.3952
280060	19.7527	20.7022	22.4677	20.9351
280061	17.1629	18.6370	20.2066	18.7084
280062	14.4896	15.6018	16.1708	15.4336
280064	16.2977	16.8330	18.2196	17.1053
280065	19.2932	20.7370	21.6999	20.6166
280066	11.6621	11.7207	12.2225	11.8688
280068	9.4943	10.5987	10.5103	10.1786
280070	17.7400	22.6201	18.7211	19.4766
280073	17.4244	17.7698	18.3496	17.8530
280074	16.4310	17.3143	13.6025	15.4955
280075	15.5327	13.2230	13.3154	13.8859

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
280076	14.8469	16.7488	16.1939	15.8857
280077	19.2068	20.0148	21.1883	20.1246
280079	10.4540	16.6117	17.1519	13.6519
280080	15.3308	16.9487	16.1902	16.1919
280081	21.0771	20.9606	23.3805	21.7809
280082	14.3399	14.6173	15.4420	14.8136
280083	18.2992	21.5336	20.8995	20.2370
280084	12.5836	13.6536	13.2158	13.1411
280085	20.4302	20.4825	20.8532	20.5742
280088	20.2961	*	*	20.2961
280089	18.1668	18.9567	19.9003	18.9565
280090	14.1362	15.1274	*	14.6858
280091	15.8436	16.1866	16.3456	16.1284
280092	14.1945	14.7912	13.3032	14.1038
280094	17.6873	16.3474	16.9180	16.9734
280097	14.1734	13.8223	14.1870	14.0603
280098	13.0029	12.5875	12.4995	12.6927
280101	13.5261	16.9973	10.5153	13.1647
280102	14.0102	*	*	14.0102
280104	13.2819	16.2167	15.5949	14.8930
280105	18.6575	21.0735	23.7103	21.1232
280106	16.1247	16.0679	16.3564	16.1791
280107	13.3311	14.4679	*	13.8480
280108	17.5625	17.1961	18.5134	17.7698
280109	12.6803	12.4408	*	12.5540
280110	12.7546	14.2136	13.0278	13.3282
280111	21.8773	19.6283	19.7688	20.3886
280114	15.7160	17.3076	17.1154	16.7114
280115	16.7041	18.1480	18.3464	17.7487
280117	17.7276	18.8279	20.3819	18.9864
280118	16.8687	18.6524	17.8891	17.8029
280123	14.0637	11.8582	23.6682	15.2035
280125	16.1332	16.3944	17.2718	16.5861
290001	22.8226	22.7450	24.3681	23.3363
290002	17.2554	16.5419	16.7948	16.8714
290003	22.8840	24.2175	25.4303	24.1777
290005	19.4888	21.9814	22.7804	21.4325
290006	21.8070	22.4063	22.4832	22.2310
290007	29.7706	30.9075	34.9911	31.9541
290008	20.6190	24.1255	26.9216	23.3785
290009	23.3620	23.9373	24.8816	24.0545
290010	15.6423	16.4476	20.8387	17.4968
290011	20.1564	21.1234	19.7410	20.3076
290012	21.8275	25.0430	25.5647	24.2464
290013	18.2713	15.7932	20.2914	17.8815
290014	18.9743	18.7829	20.2762	19.3806
290015	22.3487	19.4504	20.2336	20.6208
290016	14.3542	23.8656	21.8030	19.3661
290019	21.2509	22.2045	22.5584	22.0258
290020	20.8733	21.2380	19.5039	20.6806
290021	21.5806	22.9488	24.1397	22.9083
290022	24.5468	25.5011	25.3914	25.1625
290027	16.7786	13.3769	13.1463	14.2467
290032	22.8447	23.9504	26.9846	24.7498
290036	*	12.9074	*	12.9073
290038	20.6753	27.7030	26.0836	23.3519
290039	25.3864	25.5024	26.6283	25.8754
290041	*	25.9905	27.7740	27.0523
290042	*	18.7527	18.7669	18.7611
290043	*	27.9053	*	27.9053
300001	22.0909	23.8567	25.7142	23.9386
300003	22.9111	24.1297	25.3252	24.1024
300005	20.7545	22.2858	22.3258	21.7858
300006	23.7793	18.9745	22.2642	21.6739
300007	20.2372	20.6325	21.3633	20.7580
300008	20.7702	19.6149	20.9207	20.4237

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
300009	18.0602	20.0938	20.1486	19.3957
300010	19.3940	20.2130	21.0316	20.1973
300011	22.4325	23.0279	23.8390	23.0923
300012	24.5673	24.5619	25.8581	25.0347
300013	19.1247	20.1669	20.0269	19.7788
300014	20.3292	20.1774	21.6705	20.7353
300015	20.4916	19.6627	22.8966	21.0797
300016	21.8659	17.8148	15.1311	18.1853
300017	21.6563	22.7191	23.9651	22.8162
300018	21.2381	21.6385	22.8379	21.9548
300019	20.9753	19.6728	20.5801	20.4037
300020	21.9165	22.6627	23.0806	22.5724
300021	18.6211	19.3101	20.2585	19.4039
300022	18.3507	19.1875	20.1209	19.2058
300023	22.1210	22.7649	22.1896	22.3579
300024	19.9116	21.5842	22.2235	21.2127
300028	17.4075	20.0778	21.4207	19.6713
300029	22.5748	22.6013	23.8415	23.0427
300033	17.1869	17.1632	17.4836	17.2725
300034	25.5182	24.4975	25.2355	25.1020
310001	28.1329	27.4730	31.1568	28.9609
310002	28.3434	27.9728	28.7786	28.3714
310003	29.1096	27.5624	29.3522	28.6667
310005	22.1146	22.9712	23.9477	22.9918
310006	21.5957	22.0894	24.1538	22.5976
310008	23.5084	24.7618	26.4989	24.9206
310009	23.6371	21.7094	23.2420	22.8675
310010	22.5682	23.1060	24.5471	23.4312
310011	23.1977	24.2885	25.4900	24.3173
310012	26.5242	26.6772	28.1367	27.1332
310013	21.2251	22.5603	23.2424	22.3596
310014	27.4614	23.1956	31.0834	27.0285
310015	27.4331	27.9684	29.1340	28.1965
310016	24.3838	24.5206	26.0738	24.9281
310017	25.7902	24.5976	25.1634	25.1866
310018	22.8428	22.4779	24.1428	23.1619
310019	24.0542	24.9914	28.5952	25.8565
310020	24.1848	24.4152	25.0803	24.5523
310021	23.9369	25.4393	27.8958	25.6657
310022	21.2706	20.8258	23.3412	21.7795
310024	24.2353	24.9521	27.0459	25.4016
310025	24.3513	24.1812	25.5227	24.6926
310026	23.5491	22.1997	23.2895	22.9937
310027	21.8846	22.5696	24.4437	22.9152
310028	23.4577	23.9428	26.1931	24.5392
310029	22.6629	23.6610	24.4290	23.5772
310031	26.1567	26.6831	26.7174	26.5090
310032	24.3528	24.7404	24.9133	24.6820
310034	23.2729	24.1150	24.8567	24.0848
310036	20.1905	21.7187	23.0320	21.6137
310037	27.7823	28.1289	28.7738	28.2289
310038	26.7209	28.4893	28.1756	27.8036
310039	22.1754	22.7317	23.6605	22.8221
310040	26.1492	26.3573	26.5769	26.3634
310041	24.8960	23.5559	23.8857	24.0951
310042	23.2472	24.7678	24.9702	24.3057
310043	21.9022	21.6128	24.0238	22.3478
310044	21.6677	23.1549	23.1489	22.6676
310045	28.4854	28.9274	29.4877	28.9512
310047	25.1101	26.1921	25.9777	25.7489
310048	23.6118	25.2870	23.4189	24.0965
310049	24.8299	27.0842	25.6732	25.8686
310050	25.1752	24.7988	23.7735	24.5800
310051	27.1265	27.5378	28.6248	27.7362
310052	22.9326	23.3973	24.9773	23.7348
310054	26.1726	27.7376	27.6290	27.1447

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
310057	21.1686	22.2572	22.2630	21.9057
310058	26.5308	26.3765	25.3983	26.1966
310060	19.1992	20.0997	21.4455	20.2153
310061	23.2646	33.9582	23.4283	26.0987
310062	22.9073	*	*	22.9073
310063	21.9045	22.1080	21.2619	21.7577
310064	24.8567	25.4822	25.9350	25.4143
310067	25.0888	23.9278	24.1943	24.4277
310069	23.7531	24.2329	25.3464	24.4561
310070	26.0903	28.2220	29.5101	27.8193
310072	21.7605	22.5611	24.4480	22.8822
310073	28.5149	26.2937	26.7954	27.1681
310074	23.8340	22.3588	24.2009	23.4890
310075	23.3266	24.4788	23.9771	23.9276
310076	30.0797	27.9918	29.6667	29.2818
310077	25.2500	26.1251	26.7092	26.0055
310078	23.8841	24.0587	24.5862	24.1519
310081	22.0762	22.4086	23.3310	22.6044
310083	23.8852	24.8204	25.0191	24.5773
310084	26.6753	24.6049	25.4946	25.5858
310086	22.1674	23.1719	23.4966	22.9208
310087	20.7243	21.1215	20.6847	20.8455
310088	22.3160	23.1722	23.0610	22.8414
310090	23.8284	24.8986	23.6661	24.1303
310091	22.7978	23.2969	24.5357	23.5110
310092	20.5165	21.6964	22.9721	21.7350
310093	22.4291	23.7251	23.9404	23.3192
310096	25.1572	24.5759	26.6588	25.4191
310105	25.5891	26.2537	28.1317	26.5767
310108	22.4756	23.8308	25.1368	23.7798
310110	21.8341	23.2146	23.3461	22.8546
310111	21.1066	22.1151	23.3646	22.1990
310112	23.6701	24.7914	24.2999	24.2528
310113	23.6841	23.1961	24.2708	23.7328
310115	21.7320	21.1645	23.5148	22.1431
310116	22.9812	23.6366	24.2696	23.6118
310118	26.4625	26.1315	26.8760	26.4761
310119	33.6686	32.7858	29.1045	31.7976
310120	23.9681	23.3200	22.6526	23.3189
320001	19.1150	20.6225	21.5564	20.4107
320002	22.6175	23.0983	25.5144	23.6846
320003	15.9504	16.4642	16.4961	16.3037
320004	18.5824	19.6642	21.3681	19.9888
320005	21.6103	21.0411	22.4178	21.7283
320006	18.9019	20.3863	19.8672	19.6917
320009	18.2883	19.3500	20.3783	19.2661
320011	20.0601	18.5222	19.1476	19.2439
320012	16.4355	17.1764	17.1317	16.8928
320013	22.9573	24.5543	25.5403	24.4572
320014	16.3598	16.8412	22.9026	18.5503
320016	20.5398	18.8519	18.8763	19.4121
320017	18.6388	19.4498	20.4390	19.4898
320018	18.8479	19.2336	20.3141	19.4697
320019	24.4707	26.9637	25.1210	25.6183
320021	17.8705	19.1265	20.0089	18.9760
320022	16.1777	18.0606	20.9797	18.5397
320023	18.0548	17.8419	*	17.9685
320030	16.5495	18.6859	18.1556	17.7555
320031	19.6768	25.1715	18.2244	20.7137
320032	18.8097	20.6871	21.4815	20.2510
320033	25.0777	21.0621	21.9804	22.5777
320035	21.5186	15.0612	17.8058	17.7193
320037	17.0305	17.8280	17.6724	17.5157
320038	16.8117	22.2664	23.1987	20.9645
320046	18.3190	18.9607	19.4732	18.9435
320048	19.9642	16.8769	*	18.3467

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
320063	18.3237	17.9089	18.5600	18.2484
320065	16.7933	18.6525	22.5428	19.0210
320067	33.8654	15.3228	16.8015	18.3132
320068	17.4785	18.5103	15.6864	17.1411
320069	13.0094	14.4212	15.7350	14.3622
320074	19.3406	20.2290	22.3403	20.2679
320079	18.2828	19.8555	20.2473	19.4478
330001	26.5533	27.3996	28.6214	27.5633
330002	26.5370	26.9341	27.1811	26.8727
330003	19.4102	18.9211	19.3972	19.2414
330004	22.5298	20.9501	22.5082	22.0002
330005	24.8338	22.1957	22.6137	22.8232
330006	25.0576	25.8006	26.2970	25.7013
330007	18.9024	*	*	18.9024
330008	19.0045	19.2341	19.6770	19.3060
330009	30.6918	31.3435	30.9087	30.9793
330010	17.4512	16.6508	17.8935	17.3146
330011	18.2986	18.6748	18.7995	18.5936
330012	32.7624	*	*	32.7624
330013	19.0856	19.6269	19.0995	19.2697
330014	32.3370	36.8669	32.4496	33.8020
330016	16.9717	16.8016	18.7194	17.4483
330019	35.9822	33.5369	31.5927	33.4812
330020	15.5527	15.1142	16.6952	15.7780
330023	24.4006	25.6512	26.6997	25.5866
330024	34.1682	37.3316	35.7485	35.6717
330025	16.2033	16.8687	17.6169	16.8903
330027	33.4738	35.5255	35.1046	34.6601
330028	28.2089	29.5294	31.7699	29.9762
330029	18.1567	17.0016	19.4377	18.2068
330030	17.4977	19.1085	18.0866	18.1511
330033	18.5353	17.4444	19.5836	18.5046
330034	31.3997	27.7738	38.2451	31.3373
330036	23.9874	25.2820	25.5888	24.9782
330037	16.1140	16.4866	18.3260	16.9831
330038	16.2549	17.3429	16.2997	16.6434
330041	24.5215	31.4871	29.5305	28.1630
330043	28.7467	27.4661	28.9622	28.3990
330044	20.0238	19.5219	19.9808	19.8437
330045	28.0758	27.9919	28.5267	28.2011
330046	32.4189	35.2703	38.1184	35.1742
330047	18.1815	18.5536	19.5561	18.7655
330048	17.8787	19.1093	19.6129	18.8634
330049	19.4993	20.5731	22.1523	20.7576
330053	17.4430	17.8082	17.9161	17.7212
330055	36.1109	32.8910	34.2159	34.3472
330056	30.4525	30.0945	29.8377	30.1337
330057	18.7478	19.3643	20.0995	19.4010
330058	17.0014	17.7672	18.1007	17.6091
330059	34.1705	34.2426	35.0121	34.4519
330061	25.7331	25.4082	26.8580	25.9786
330062	17.6067	18.1318	18.4662	18.0774
330064	33.1269	33.6447	35.1422	33.9496
330065	19.8940	19.9305	20.1615	19.9917
330066	19.5611	18.8707	19.3644	19.2586
330067	20.9443	22.1065	23.6836	22.2657
330072	30.8019	30.4171	30.3737	30.5362
330073	16.2898	16.4518	16.5166	16.4181
330074	18.0005	17.7308	18.9326	18.2224
330075	17.2298	17.6385	19.2938	18.0353
330078	16.7949	18.7884	18.0362	17.8405
330079	17.4555	18.7622	18.9398	18.3917
330080	29.2686	31.4424	34.6880	31.6540
330084	18.0435	19.3216	19.0261	18.8002
330085	20.2926	20.6203	20.9332	20.6126
330086	31.2980	23.6496	26.2979	27.1579

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
330088	25.6626	25.7940	26.7583	26.0739
330090	19.3954	19.2112	20.1344	19.5790
330091	19.0953	19.7776	21.6004	20.1526
330092	14.0671	13.3723	17.2083	14.8861
330094	17.5585	18.1582	18.8941	18.2051
330095	20.1073	21.1096	21.1809	20.7563
330096	17.9641	18.5149	20.0370	18.8403
330097	16.2169	16.4433	16.1945	16.2798
330100	27.0661	29.0916	28.9956	28.3021
330101	32.4105	31.5914	35.3618	33.2017
330102	17.5755	19.0058	21.0057	19.0881
330103	15.7197	16.8110	17.3511	16.6312
330104	31.6471	31.2074	31.9746	31.6063
330106	40.2686	35.3775	36.2526	37.1762
330107	28.5580	27.7797	28.9225	28.4199
330108	17.3605	18.0786	18.5849	17.9950
330111	19.5314	15.9321	13.3352	15.9787
330114	17.3522	17.0581	19.1162	17.8316
330115	17.4430	17.4684	18.5911	17.8343
330116	24.4622	14.9610	16.8567	18.1237
330118	20.6936	*	*	20.6936
330119	34.8385	33.1179	33.5653	33.8391
330121	16.1052	16.3385	17.1869	16.5359
330122	20.8204	20.2417	23.0384	21.3559
330125	19.8494	19.7638	20.5922	20.0689
330126	23.7938	23.8957	25.1175	24.2981
330127	31.9046	30.7356	40.0112	34.3173
330128	29.0222	30.8242	34.3468	31.2952
330132	15.7633	14.3673	14.8704	15.0313
330133	37.2494	35.3576	37.5192	36.5906
330135	18.7120	22.2670	23.5662	21.3289
330136	18.2422	20.1043	20.4124	19.5654
330140	19.1438	19.3615	21.1841	19.9069
330141	26.4956	26.7096	27.5960	26.9363
330144	14.0566	16.2517	17.1513	15.7880
330148	16.8151	16.2782	16.7251	16.6024
330151	16.0714	15.7594	15.2233	15.6663
330152	30.5409	30.8314	33.5587	31.5460
330153	18.9689	18.1776	19.4417	18.8671
330157	22.0792	22.3804	23.1743	22.5628
330158	25.7569	27.1228	29.3163	27.3406
330159	19.1536	19.4998	20.2753	19.6267
330160	32.7840	29.5885	30.7893	30.9997
330162	27.1166	27.6010	27.9705	27.5570
330163	18.7816	20.7456	21.4143	20.2444
330164	19.8647	20.9003	22.0699	20.9292
330166	15.0954	15.4420	17.0637	15.8309
330167	29.3634	30.2346	32.0541	30.4443
330169	37.2655	35.4794	36.3690	36.3400
330171	25.5307	24.8035	25.1567	25.1635
330175	17.3290	18.3116	18.8701	18.1413
330177	17.2907	16.3704	16.6059	16.7542
330179	13.4999	13.8953	16.0113	14.4058
330180	16.8787	17.9877	19.2670	17.9995
330181	32.5192	33.0908	34.6065	33.3779
330182	32.9371	33.6531	33.3363	33.3137
330183	19.9207	20.6164	20.3520	20.2984
330184	30.0400	31.3706	28.4726	30.0103
330185	25.6112	26.8612	27.8894	26.7722
330188	20.9587	18.8000	20.2849	20.0186
330189	15.1253	18.4498	23.5589	18.7634
330191	18.6206	19.0348	19.5623	19.0759
330193	36.5481	30.2260	32.5496	32.9872
330194	34.6785	35.2036	35.6486	35.1819
330195	33.3254	34.8966	34.4689	34.2028
330196	30.8165	30.5799	28.9488	30.1409

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
330197	17.6646	18.3527	19.2237	18.4045
330198	24.6038	24.8590	25.6669	25.0413
330199	28.7609	30.5409	28.0374	29.1320
330201	32.1149	28.7861	30.0524	30.3389
330202	31.4435	31.2575	35.4943	32.7201
330203	20.7575	25.0345	25.9211	23.7716
330204	29.4418	32.2005	31.1366	30.8772
330205	20.5793	22.3490	24.9040	22.5611
330208	26.1822	26.6682	27.3170	26.7219
330209	23.9924	25.1281	27.0257	25.4421
330211	19.5064	19.5405	20.0006	19.6855
330212	21.7705	24.7681	24.8554	23.7568
330213	18.7722	19.6796	20.1166	19.4878
330214	36.4447	32.4292	32.3130	33.3200
330215	19.6926	17.9863	19.0726	18.8818
330218	21.4796	21.1890	21.4747	21.3812
330219	23.9908	23.4310	25.1792	24.1748
330221	27.8485	33.3796	32.5044	31.2700
330222	18.3666	18.5571	19.3148	18.7515
330223	17.6199	17.8306	19.1604	18.2153
330224	19.6410	20.4309	20.5881	20.2163
330225	25.5823	27.0379	28.0523	26.7760
330226	16.6711	23.1859	21.6368	20.2080
330229	16.8026	17.5326	18.2554	17.5103
330230	29.7626	29.6283	30.6937	29.9984
330231	30.0923	32.7200	32.4163	31.6314
330232	17.9083	19.1787	20.0924	19.0447
330233	30.9241	44.1265	43.1186	38.2032
330234	35.1777	35.0720	35.8327	35.3617
330235	21.0842	19.5880	20.1255	20.2820
330236	29.5913	31.3463	32.1246	30.9874
330238	15.6245	17.3976	17.8867	16.9394
330239	17.4462	18.5079	18.9953	18.2764
330240	29.7082	30.7321	35.6576	31.8043
330241	24.6076	23.8638	24.7545	24.4065
330242	28.2612	27.6384	28.3561	28.0883
330245	17.6767	18.5161	20.7605	19.0556
330246	28.1090	28.1205	29.8777	28.6473
330247	28.5310	27.3937	32.5858	29.3555
330249	16.2687	17.1320	17.6846	17.0482
330250	19.5823	19.9619	20.8742	20.1545
330254	18.4057	15.9123	15.7864	16.7695
330258	29.7426	31.8910	32.6745	31.4411
330259	26.2661	25.9994	26.3620	26.2118
330261	25.7244	27.9766	30.0489	27.8583
330263	20.4149	18.7378	19.5057	19.6112
330264	22.8672	22.8099	24.9714	23.5858
330265	18.0193	17.6301	21.1215	18.8985
330267	24.5183	24.5939	27.8255	25.6678
330268	13.0595	15.9060	16.8358	15.2987
330270	34.4254	36.0824	33.0375	34.5188
330273	23.1511	26.0565	27.0454	25.3482
330275	19.0548	18.7268	*	18.9109
330276	18.2870	19.0228	19.6572	18.9869
330277	18.3169	19.1761	20.7851	19.4340
330279	19.5983	20.7107	21.7827	20.6371
330285	23.5264	24.0491	24.5388	24.0351
330286	26.7633	27.7762	28.0994	27.5677
330290	33.5056	30.4706	34.3439	32.7503
330293	16.2158	16.9238	17.3180	16.7809
330304	26.7683	27.3562	29.2207	27.7999
330306	27.3798	29.5937	29.6641	28.8531
330307	21.0673	21.7257	23.2838	22.0498
330314	24.5444	25.9937	25.5405	25.3155
330316	27.6102	27.9543	27.9277	27.8310
330327	16.4611	20.3874	20.1705	18.8688

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
330331	31.6216	33.1276	32.3249	32.3864
330332	27.6914	25.3689	27.6955	26.9473
330333	29.1931	*	28.8819	29.0166
330336	29.7689	29.8294	27.9163	29.1955
330338	22.4581	21.2670	23.6142	22.4472
330339	20.0111	20.1028	20.2382	20.1121
330340	28.8419	28.4129	28.2732	28.5256
330350	30.8889	30.9763	33.5493	31.7771
330353	32.1984	34.2431	34.2260	33.5106
330357	36.5928	34.1846	36.8598	35.8981
330372	28.8482	33.3771	23.5381	28.1605
330381	31.0091	31.8602	*	31.4219
330385	35.6722	33.2246	37.5523	35.5897
330386	17.6383	20.4231	21.4363	19.4104
330389	30.2505	37.3749	33.1192	33.1975
330390	31.1577	30.8744	31.7344	31.2381
330393	26.4958	27.8352	31.9272	28.5908
330394	19.2392	18.9343	19.6892	19.2847
330395	32.8749	32.7494	33.2318	32.9405
330396	34.8648	30.7961	32.8517	32.9044
330397	33.9061	32.6068	34.6435	33.6607
330398	28.7707	29.2872	*	28.9084
330399	32.9100	33.3012	32.7149	32.9707
330400	*	16.2707	16.8168	16.5566
340001	18.1814	19.7093	22.0257	19.9576
340002	20.8858	20.5253	22.9425	21.5738
340003	20.2540	19.5145	19.6545	19.8018
340004	19.0695	20.9863	23.0890	21.0811
340005	15.8205	16.7176	16.6909	16.4458
340006	16.9818	16.5709	16.1379	16.5756
340007	17.2356	18.3399	18.3760	17.9959
340008	21.2889	20.4157	22.6570	21.4924
340009	20.5023	20.9178	20.6155	20.6734
340010	18.3380	19.4302	20.6547	19.5049
340011	13.6554	14.4798	17.4534	15.1697
340012	18.8701	17.5112	19.3651	18.5479
340013	20.1747	19.4613	21.5130	20.3981
340014	20.5748	27.7888	21.9804	22.9126
340015	20.1562	19.4676	20.3493	19.9875
340016	17.5404	18.8958	19.4160	18.6049
340017	19.4192	20.2775	20.6263	20.1119
340018	14.0930	18.1751	16.4611	16.0927
340019	14.8980	15.2887	15.9037	15.3369
340020	18.6334	18.0897	19.2392	18.6598
340021	19.8020	20.5813	22.0220	20.7507
340022	17.8178	18.7714	20.6484	19.0742
340023	18.5414	19.3146	19.9023	19.2892
340024	17.3824	17.9130	19.1430	18.1515
340025	17.2648	18.4628	19.1770	18.3029
340027	18.0816	19.4548	19.4907	19.0172
340028	18.4787	19.9403	20.6496	19.7560
340030	21.1420	22.4709	23.9505	22.4602
340031	14.6951	14.6370	15.4935	14.9011
340032	20.0049	20.7444	22.0245	20.9102
340035	20.2312	18.9930	18.5883	19.2823
340036	18.2190	17.7619	18.4203	18.1226
340037	16.6576	17.5829	18.3655	17.5271
340038	17.3762	18.1493	20.3091	18.5547
340039	20.5876	21.3711	22.4020	21.4803
340040	20.4282	20.7237	21.1397	20.7708
340041	15.1419	15.5873	16.3200	15.6803
340042	16.9298	17.0034	19.1386	17.6977
340044	18.8687	18.0863	18.9562	18.6425
340045	13.0538	13.6182	20.2641	14.9554
340047	20.0602	20.0744	21.5178	20.5318
340049	19.2050	19.5127	17.2986	18.6550

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
340050	20.0090	19.6726	20.6831	20.1383
340051	16.5617	19.3627	19.0282	18.2702
340052	22.8173	23.2134	26.2243	23.8462
340053	20.9495	19.9915	23.2410	21.3227
340054	15.5993	15.5090	16.6208	15.8560
340055	19.6056	19.4035	20.8253	19.9607
340060	18.7137	19.3410	20.8570	19.6422
340061	21.5385	22.1175	23.7173	22.4390
340063	17.0249	16.7377	26.4132	19.5650
340064	20.7125	18.5069	17.6106	18.8953
340065	17.5414	17.3530	23.2606	18.9401
340067	19.3785	19.7187	22.4054	20.2943
340068	16.6305	17.8065	18.8758	17.7729
340069	21.0840	21.6728	22.5995	21.8080
340070	19.7796	20.6829	21.3511	20.6142
340071	17.1424	18.0767	19.3679	18.2275
340072	16.7400	17.7129	18.7920	17.7544
340073	21.9761	23.5832	24.0794	23.2689
340075	18.7090	20.0081	19.7450	19.4817
340080	22.2533	18.2061	*	20.1809
340084	17.1532	19.0103	19.6087	18.5190
340085	17.3462	18.3179	20.3684	18.6708
340087	17.3884	18.2255	20.2445	18.6743
340088	21.0226	22.2322	22.6462	21.9702
340089	13.8535	15.4760	16.1321	15.1566
340090	17.0584	18.5287	18.7701	18.1576
340091	20.5923	20.3861	21.2665	20.7762
340093	16.3276	16.8903	16.5452	16.5873
340094	19.0406	*	21.0091	20.0488
340096	17.8189	19.4696	20.9686	19.4268
340097	18.8412	18.2399	20.0302	19.0440
340098	21.4135	21.9578	23.4949	22.3232
340099	16.8305	15.3752	16.9979	16.3421
340101	13.9994	15.6509	20.7841	16.3562
340104	13.0462	11.5169	12.1845	12.2454
340105	20.2954	*	*	20.2954
340106	17.7220	18.1211	19.1147	18.3112
340107	18.0205	19.3197	20.7601	19.3267
340109	18.7746	19.0532	19.3357	19.0640
340111	16.3344	16.5976	17.2127	16.7260
340112	14.7562	15.5142	16.9592	15.7587
340113	21.2906	21.9883	24.4222	22.5465
340114	21.2166	20.7261	21.7750	21.2327
340115	19.7578	21.7586	24.7924	21.8733
340116	20.4255	20.6800	21.6744	20.9328
340119	18.8507	19.5827	20.5394	19.6919
340120	15.0410	15.8240	16.9847	15.9742
340121	16.3295	17.8771	19.0420	17.7638
340123	16.9114	18.9078	21.5041	19.1720
340124	15.5779	17.4185	17.5411	16.8707
340125	19.7164	20.2748	*	19.9923
340126	18.8100	19.3734	21.2045	19.7489
340127	19.3925	19.3842	21.4797	20.0982
340129	20.4605	20.6521	21.0773	20.7569
340130	19.7422	19.8707	20.5851	20.0891
340131	19.7908	21.3849	23.2478	21.4650
340132	17.3448	17.5711	17.7110	17.5495
340133	16.4766	17.2138	17.5170	17.0631
340137	21.0249	31.7702	39.9826	26.4042
340138	20.7618	*	*	20.7618
340141	21.3754	21.4986	23.2961	22.0643
340142	17.1525	18.0766	18.1824	17.8038
340143	21.3604	24.4098	21.9304	22.5287
340144	20.9113	22.9183	22.8634	22.2296
340145	20.1081	19.9233	21.5958	20.6005
340146	15.9203	17.3051	19.1306	17.3989

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
340147	19.6827	20.5520	21.5912	20.6397
340148	18.5875	18.9912	20.6790	19.3782
340151	16.7275	18.4733	19.0779	18.0943
340153	20.6420	20.7533	21.7375	21.0743
340155	20.5792	23.1021	25.0965	22.9070
340158	18.1439	19.0843	20.0921	19.1509
340159	17.3893	19.0338	19.4992	18.6617
340160	16.1778	16.7170	17.1963	16.7262
340162	14.3472	*	*	14.3474
340164	21.2523	21.5769	*	21.4120
340166	20.0434	20.8270	22.0519	21.0278
340168	15.2919	15.6071	15.4250	15.4443
340171	21.5973	22.4779	22.7304	22.3095
340173	19.3353	21.0898	23.3690	21.3475
350001	14.9080	16.6551	15.6193	15.7235
350002	17.5259	18.3459	19.1931	18.3399
350003	18.2470	19.2840	20.0663	19.1912
350004	20.6518	23.7016	25.1976	23.1394
350005	18.3792	19.9156	20.7467	19.6757
350006	18.4107	19.0343	19.1257	18.8317
350007	13.3292	13.8824	13.9966	13.7234
350008	20.4777	22.3783	23.4052	22.0656
350009	19.1611	18.3688	19.3668	18.9603
350010	16.2808	16.6272	16.7774	16.5574
350011	18.2008	19.1944	20.6809	19.2312
350012	15.7033	18.2524	16.0990	16.7533
350013	16.4579	17.2596	17.8145	17.1631
350014	16.8403	18.0999	18.6786	17.8036
350015	16.3397	17.1071	17.5658	16.9655
350016	11.6524	*	*	11.6524
350017	17.6278	17.5124	18.0840	17.7360
350018	14.4928	16.4939	16.3210	15.7222
350019	19.3063	20.1608	20.6743	20.0169
350021	16.2898	17.7123	16.3394	16.7592
350023	17.9048	17.4983	18.3253	17.9187
350024	14.7529	15.4788	15.7510	15.3010
350025	17.1199	15.0469	14.6099	15.5234
350027	15.0835	15.5178	17.5882	15.9431
350029	13.5219	14.6173	*	14.0747
350030	17.7209	18.1131	18.7993	18.2025
350033	14.9012	16.0870	16.0903	15.6588
350034	18.7245	19.6445	*	19.1773
350035	10.4570	11.7675	12.6496	11.6111
350038	17.6666	19.6854	19.5497	18.9137
350039	17.0361	16.6278	14.8599	16.1842
350041	14.6680	19.1341	23.1150	18.5427
350042	16.7402	19.3309	19.3370	18.2440
350043	16.8876	16.7433	17.6722	17.1008
350044	10.2154	11.0601	10.9690	10.7163
350047	14.4628	18.0094	19.9749	17.4882
350049	14.8019	18.1993	16.8322	16.4660
350050	11.4921	12.2183	25.2747	13.9652
350051	17.7279	17.0653	16.9201	17.2392
350053	14.6398	15.9160	16.7456	15.7135
350055	14.5691	15.7916	16.1691	15.5004
350056	14.8293	15.0995	15.7752	15.2147
350058	15.9378	16.7034	16.1013	16.2607
350060	10.3666	10.3076	10.5325	10.3988
350061	15.7269	18.8790	19.6460	18.1394
360001	17.0791	19.6655	20.3515	18.9788
360002	18.0139	18.2613	19.6145	18.5918
360003	22.7471	22.7521	23.2905	22.9196
360006	21.8048	22.4436	22.6333	22.2902
360007	18.0941	14.8213	15.3656	16.0665
360008	18.5439	18.7961	19.8034	19.0500
360009	18.9322	18.9935	19.6277	19.2000

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
360010	19.2288	19.1852	20.5934	19.6922
360011	19.3835	21.3659	19.5383	20.0283
360012	19.9881	20.0525	23.0125	21.0366
360013	20.6021	21.3690	22.3407	21.4314
360014	20.2390	20.7419	22.9930	21.3333
360016	17.8065	21.2505	21.3967	20.0182
360017	21.7543	22.2740	22.7446	22.2365
360018	23.5219	24.6686	24.6694	24.2429
360019	18.7147	20.6480	21.4708	20.1693
360020	21.7806	22.1751	21.6607	21.8722
360024	19.8508	20.1352	20.9408	20.3040
360025	20.3638	20.2531	20.9266	20.5175
360026	18.2222	17.9523	18.6739	18.2838
360027	21.0406	21.7650	22.8098	21.8716
360028	17.0177	18.7174	*	17.7935
360029	18.7622	19.2928	19.7466	19.2762
360030	17.5748	17.6058	19.0551	18.0921
360031	19.3858	21.0687	21.0481	20.5037
360032	18.6559	19.8020	19.8367	19.4058
360034	14.9534	17.9594	19.4982	17.4782
360035	20.5557	21.0674	22.6982	21.4596
360036	20.2107	20.9916	21.4486	20.8814
360037	23.5094	23.1674	23.7504	23.5019
360038	21.2467	19.9415	21.4804	20.8884
360039	18.7791	19.0013	19.3703	19.0512
360040	18.1618	18.7425	19.9750	18.9827
360041	19.5744	19.7968	21.9093	20.5114
360042	17.4306	17.1952	19.3774	17.9518
360044	17.0612	17.6882	17.8417	17.5521
360045	22.1471	22.4018	22.8112	22.4244
360046	20.4755	20.4607	21.4292	20.8030
360047	17.1871	15.2922	15.8279	16.0315
360048	22.5857	22.4890	25.6259	23.4295
360049	20.4564	20.8393	*	20.6400
360050	12.9873	15.0568	15.6847	14.5392
360051	20.8338	20.8757	21.2225	20.9792
360052	19.6233	18.7931	19.8037	19.4032
360054	17.2574	17.4911	17.5714	17.4428
360055	21.5585	21.4112	22.8755	21.9415
360056	19.0474	20.6968	23.4405	21.1066
360057	15.0146	15.8569	16.0395	15.6552
360058	18.6992	19.3306	19.0440	19.0197
360059	20.5618	19.9304	23.2129	21.1909
360062	20.7588	21.9195	24.4898	22.4391
360063	18.4512	17.5108	20.2671	18.6964
360064	20.4846	20.0615	20.7659	20.4360
360065	20.0532	19.6199	22.3443	20.6667
360066	21.6015	22.8175	24.1295	22.8841
360067	15.3157	14.2745	17.3734	15.6086
360068	21.2789	22.6227	22.6027	22.1750
360069	16.6982	14.6597	18.5382	16.4901
360070	17.3758	18.8406	19.4700	18.5552
360071	17.9756	19.0302	19.6873	18.9152
360072	18.1467	19.0166	20.8819	19.3874
360074	20.8275	18.5889	19.9947	19.7927
360075	22.4523	26.0663	27.6992	24.6791
360076	20.0700	20.3317	21.0402	20.4919
360077	21.1053	21.5517	22.2964	21.6371
360078	21.4392	22.6490	22.7743	22.2897
360079	22.1096	21.6644	23.9491	22.5122
360080	17.3892	17.6369	18.0392	17.6871
360081	21.7342	20.4614	20.7477	20.9963
360082	22.9460	20.7610	22.9390	22.1817
360084	20.4894	22.0492	22.1699	21.5674
360085	21.9051	21.5151	24.8010	22.5708
360086	19.5378	19.3701	20.5858	19.8561

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
360087	20.1684	20.7969	21.1621	20.7100
360088	24.0097	24.0822	20.5703	22.7567
360089	18.3881	18.1941	19.5260	18.6947
360090	21.0376	20.8971	21.2072	21.0517
360091	21.3126	21.8447	22.6510	21.9522
360092	20.4534	21.5073	20.9588	20.9684
360093	19.3292	19.0261	21.0134	19.7919
360094	18.8780	20.1227	21.1952	20.0119
360095	20.4149	19.8521	21.3505	20.5395
360096	18.2215	19.6726	20.9838	19.6144
360098	19.5314	19.8178	20.8049	20.0522
360099	18.5855	19.6241	20.8801	19.7171
360100	17.8989	18.0442	19.9768	18.5656
360101	21.3914	20.2635	24.1551	21.8064
360102	19.4345	18.5367	*	19.0252
360106	18.9752	19.1778	18.9779	19.0463
360107	19.7599	22.1359	21.9939	21.3334
360108	17.5832	20.0681	19.0649	18.8939
360109	20.1032	19.9237	17.3564	18.9331
360112	22.5589	24.6335	25.7920	24.1917
360113	24.2654	20.8154	22.8088	22.5276
360114	17.8761	18.7509	19.4212	18.7051
360115	18.8059	20.7652	21.0104	20.2115
360116	18.8882	18.8319	20.1408	19.2675
360118	19.3732	19.9141	21.0235	20.1425
360121	22.1093	22.2175	21.9111	22.0788
360123	20.3236	20.9792	21.9985	21.1330
360125	19.0774	20.5508	21.6675	20.3325
360126	19.0036	24.5387	*	21.4419
360127	17.5882	16.5559	18.2150	17.4610
360128	16.1243	17.0515	17.5557	16.8979
360129	15.5002	16.6114	17.2309	16.4330
360130	17.2009	18.4539	19.8906	18.4639
360131	19.2241	18.4688	20.4123	19.3509
360132	19.9171	21.3493	21.0162	20.7647
360133	19.4316	20.2857	22.1957	20.5231
360134	20.6876	20.9564	21.6081	21.0768
360136	17.7827	18.2194	18.5687	18.1837
360137	20.1756	22.3648	23.1867	21.8635
360140	20.2791	21.2881	18.3463	19.9463
360141	23.0016	23.5343	23.5980	23.3798
360142	17.0059	18.3188	19.6189	18.3226
360143	20.1989	21.0336	20.9158	20.7118
360144	23.2191	20.9033	20.9386	21.6583
360145	19.6413	20.0513	21.2931	20.3252
360147	16.6616	17.6779	18.7258	17.7129
360148	19.2816	19.1393	20.3120	19.5918
360149	19.9808	*	*	19.9808
360150	21.1327	22.3620	23.1858	22.2110
360151	16.6019	19.2788	20.5594	18.6756
360152	20.8328	21.6005	20.9704	21.1340
360153	15.4132	16.7399	16.1021	16.0822
360154	14.3270	14.3593	14.9606	14.5355
360155	22.5347	22.2112	22.3347	22.3576
360156	17.8787	18.9095	19.9382	18.8811
360159	20.2841	21.5695	22.7992	21.5782
360161	19.1983	20.6160	19.6266	19.8098
360163	20.7275	21.2689	22.1012	21.3886
360165	18.2571	18.2417	19.6205	18.6959
360166	18.7321	*	*	18.7321
360170	16.4653	20.4407	19.7980	18.7693
360172	18.6720	19.8909	22.3294	20.3872
360174	19.9725	20.5399	20.5874	20.4239
360175	21.1685	21.5450	22.0274	21.5958
360176	15.9430	16.6228	17.6743	16.7422
360177	18.7898	18.9576	19.6992	19.1509

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
360178	18.8704	16.7962	18.0773	17.9514
360179	21.1309	20.7069	21.3520	21.0546
360180	21.3826	21.0146	22.9260	21.7254
360184	19.1224	*	*	19.1224
360185	18.7291	19.4858	20.0848	19.4376
360186	18.3246	20.7572	18.1254	19.0367
360187	18.5109	19.6535	20.8423	19.6414
360188	17.1044	18.3057	16.4329	17.3292
360189	17.8981	18.5940	19.0481	18.4968
360192	21.6365	22.7846	23.9969	22.7928
360194	17.1884	17.6140	19.3901	18.0653
360195	19.9302	20.5828	21.2801	20.6088
360197	20.0603	20.5062	21.6110	20.7240
360200	16.2306	17.9623	19.5866	17.8050
360203	16.3181	15.9609	17.9698	16.7236
360204	22.2494	*	*	22.2494
360210	20.9955	21.8629	21.5961	21.4839
360211	19.9895	20.6081	22.0011	20.8512
360212	21.1123	20.6987	21.0632	20.9556
360213	19.4765	19.0584	20.5448	19.6749
360218	18.9469	18.8204	20.7709	19.5181
360230	21.9763	20.8042	21.2417	21.3193
360231	12.9588	14.4168	12.7388	13.3090
360234	23.2588	20.6131	21.0473	21.6050
360236	17.8426	21.4628	20.5683	19.8573
360239	20.1854	19.2375	20.9440	20.0997
360241	23.5318	25.3741	23.7679	24.1749
360243	14.8694	*	*	14.8694
360245	16.4622	15.9782	16.7956	16.4127
360247	16.3092	17.0776	*	16.6743
360249	*	25.4331	*	25.4330
360250	*	*	50.5106	50.5105
370001	22.5214	24.1929	22.0586	22.8881
370002	14.7315	15.4333	16.1853	15.4106
370004	19.3236	18.5233	22.5027	20.0512
370005	15.1654	15.3881	*	15.2760
370006	16.6484	16.4995	15.7367	16.2765
370007	15.2905	15.8312	14.4961	15.2449
370008	16.6566	17.5553	18.5253	17.5877
370011	14.9701	15.6178	16.1757	15.5584
370012	11.7265	12.4942	13.3824	12.5268
370013	19.3398	18.9584	19.3237	19.2083
370014	20.6512	20.2858	22.7976	21.2589
370015	17.0319	20.8765	18.9169	18.8656
370016	19.1191	19.1613	20.0888	19.4559
370017	12.6400	13.6531	*	13.1855
370018	18.5107	17.7054	18.7928	18.3360
370019	14.2277	14.6216	16.1367	14.9616
370020	14.3798	15.1035	15.6057	15.0288
370021	12.0474	12.9030	*	12.4760
370022	17.2344	17.3724	18.2109	17.5986
370023	17.7630	17.5148	18.1255	17.8019
370025	17.4988	18.4815	19.1013	18.3736
370026	18.3371	18.0412	18.6982	18.3516
370028	18.4445	21.1292	22.1765	20.5544
370029	16.4924	18.2580	19.3285	17.9453
370030	16.3269	16.5803	18.4568	17.1242
370032	18.2821	18.1538	18.9050	18.4517
370033	13.5216	11.3210	15.3857	13.3051
370034	15.6386	15.6288	16.2204	15.8253
370035	25.5764	*	*	25.5764
370036	12.4026	12.4070	11.7667	12.1865
370037	16.7012	18.9556	20.6493	18.6793
370038	13.3084	13.0210	15.4551	13.8393
370039	15.5206	19.4498	22.7015	19.0508
370040	14.4672	15.5109	16.8127	15.5746

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
370041	16.7356	16.2316	14.7346	15.7346
370042	14.9175	15.2764	15.9005	15.3820
370043	15.9534	17.0892	20.0991	17.5940
370045	10.1994	11.3560	11.6163	10.9883
370046	18.8334	*	*	18.8333
370047	16.7554	17.8769	18.4743	17.6862
370048	18.2150	15.6803	17.0785	16.9957
370049	20.7176	19.4868	20.3405	20.1537
370051	11.6736	12.5171	11.4943	11.8576
370054	16.9049	18.0787	19.2294	17.9957
370056	18.4558	18.1432	19.2867	18.6158
370057	16.7261	15.1228	16.0301	15.9579
370059	18.1386	18.3314	21.3103	19.2182
370060	16.5403	19.3051	17.9469	17.9209
370063	14.4132	16.7342	*	15.4260
370064	10.9676	11.9954	11.6347	11.5257
370065	16.6898	18.1349	18.2406	17.6615
370071	16.1439	16.4567	*	16.2906
370072	14.4742	13.6519	12.5765	13.5464
370076	13.5694	14.3555	15.4067	14.4469
370078	18.4086	19.2412	15.2513	17.4148
370079	16.6861	16.9201	17.5915	17.0209
370080	13.9239	14.7323	14.3546	14.3090
370082	13.9634	15.0669	16.9715	15.2230
370083	13.1519	13.1810	15.6824	14.0210
370084	22.0545	13.1197	15.6184	16.0638
370085	11.2842	48.1271	13.7216	15.1761
370086	15.4404	11.1900	*	13.0199
370089	16.0966	17.2638	17.9243	17.0970
370091	19.1698	20.1822	20.8536	20.0799
370092	14.9802	15.7678	16.8432	15.8798
370093	18.4600	19.7008	22.1966	20.1375
370094	18.0002	19.5462	19.5565	19.0506
370095	12.6383	13.4202	14.5909	13.5521
370097	22.9714	23.2056	19.3793	21.5888
370099	15.4549	19.4646	18.1467	17.5179
370100	14.0168	18.8274	12.9784	15.1185
370103	19.2353	18.2685	23.1347	19.9596
370105	21.3352	20.7890	25.1252	22.1529
370106	18.5485	20.3651	21.8937	20.2077
370108	12.3279	12.7470	14.0190	13.0228
370112	14.8539	15.3039	14.3384	14.8216
370113	16.1046	17.6107	20.3439	17.9275
370114	16.5268	17.8941	17.9757	17.4836
370121	22.5611	21.3099	20.5488	21.4026
370122	15.0645	15.4375	*	15.2280
370123	18.9159	19.0313	19.7958	19.2564
370125	15.6284	13.9436	14.4664	14.6695
370126	23.9654	15.8020	*	19.5933
370131	17.5689	15.7261	*	16.5772
370133	10.9575	12.9545	16.1855	13.3276
370138	16.4005	17.5551	17.4574	17.1263
370139	14.8612	14.9964	16.0898	15.3115
370140	16.0721	17.1393	17.4950	16.9403
370141	18.4101	20.7798	19.8606	19.6250
370146	12.6402	13.0399	13.9900	13.2166
370148	20.6458	20.6612	22.6237	21.3227
370149	16.1850	17.0929	18.0699	17.1239
370153	17.8352	16.4669	16.5267	16.9839
370154	15.5127	15.6093	16.6687	15.9283
370156	13.9255	14.5696	15.4303	14.6173
370158	15.6917	15.6994	16.3637	15.9128
370159	28.0536	21.1267	25.5592	24.1706
370163	17.6361	20.4217	*	18.9027
370165	13.0910	13.0375	12.9569	13.0294
370166	17.2849	21.0797	19.4219	19.1747

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
370169	12.5243	12.7138	14.8384	13.3173
370176	15.9476	18.9951	19.6537	18.1230
370177	11.2536	14.6481	14.1304	13.3001
370178	10.5726	11.6200	9.8655	10.5383
370179	17.2829	21.3002	23.8404	20.1287
370183	10.2945	16.9318	16.6061	14.0419
370186	13.6192	15.4533	16.3671	15.1316
370190	14.1397	19.3570	20.6398	17.5727
370192	18.4614	19.6967	21.8343	20.0562
370198	21.3136	*	*	21.3136
370200	*	22.5299	18.3941	20.2627
370201	*	*	18.2548	18.2548
370202	*	*	16.5384	16.5384
370203	*	*	23.5454	23.5454
380001	20.3127	26.4822	25.1542	23.6052
380002	24.0241	21.9185	23.2479	22.9299
380003	21.7826	20.9007	23.8074	22.1844
380004	23.1451	23.3609	24.5418	23.6963
380005	24.0838	25.0750	24.7476	24.6467
380006	21.2731	21.3520	20.5914	21.0574
380007	25.2995	32.2678	25.9239	27.5188
380008	20.7063	22.3004	21.6133	21.5417
380009	23.8104	24.3851	25.1040	24.4366
380010	23.7488	22.7276	24.1931	23.5774
380011	21.1151	20.3357	20.6759	20.7167
380013	18.6818	19.8180	19.9606	19.4970
380014	24.6574	25.9828	26.6038	25.7705
380017	26.0578	25.3954	21.9236	24.5037
380018	22.3525	22.9822	24.8661	23.4431
380019	22.1215	20.8176	21.1743	21.3400
380020	20.1464	22.9568	23.9978	22.4898
380021	21.1590	23.8499	24.4365	23.1615
380022	22.6408	24.5974	25.6255	24.2510
380023	20.5462	21.3831	23.4328	21.9485
380025	26.3652	26.9346	26.9398	26.7561
380026	20.4706	20.6972	22.7561	21.3218
380027	20.8647	21.5490	22.2573	21.6028
380029	19.4246	20.1471	22.0371	20.5671
380031	23.3181	20.3396	23.7634	22.5126
380033	25.2454	27.1343	26.6899	26.3003
380035	22.4099	23.9719	25.6016	23.9444
380036	27.1587	27.2157	*	27.1858
380037	21.9158	22.1774	23.4798	22.5697
380038	26.0869	26.7759	28.1436	26.9990
380039	23.1746	22.8048	25.7614	23.8428
380040	26.2717	22.5477	22.6412	23.5906
380042	21.1176	24.4172	21.6793	22.3496
380047	23.0718	24.2524	25.2591	24.2189
380048	17.5885	18.3005	18.2773	18.0623
380050	20.3934	20.3205	22.1089	20.9066
380051	22.3568	22.3207	24.4081	23.0351
380052	19.4570	18.6299	20.7431	19.6320
380056	19.5185	18.4961	20.7895	19.6447
380060	24.2670	24.2059	23.0106	23.8515
380061	22.3736	22.8781	24.1121	23.0785
380062	20.7716	18.2148	26.1370	21.8465
380063	20.4077	*	*	20.4077
380064	19.9826	22.9160	27.0627	23.2662
380065	26.1404	22.9608	23.3146	24.0398
380066	22.0349	23.2794	23.1175	22.8287
380068	22.3178	*	*	22.3178
380069	19.8300	20.4882	21.2057	20.5172
380070	27.2541	27.7790	29.9706	28.3711
380071	22.6386	25.1808	25.9113	24.6318
380072	19.1553	19.4346	20.6568	19.7391
380075	22.3625	22.4139	23.1910	22.6625

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
380078	20.2507	21.0903	22.6996	21.3468
380081	20.9882	20.4082	22.9805	21.4341
380082	22.2275	22.9606	23.7927	23.0290
380083	21.3859	21.7431	22.4058	21.8126
380084	24.2844	27.1689	31.0111	27.0317
380087	16.5309	17.0380	21.3119	18.4448
380088	21.5225	19.5346	24.8158	21.8578
380089	19.5255	25.2908	26.1967	23.9671
380090	29.2702	24.9351	30.4223	28.0439
380091	27.5560	25.3062	28.7846	27.2892
390001	19.2989	19.6732	20.3350	19.7868
390002	21.8353	19.7833	20.8831	20.8859
390003	17.1371	18.1025	18.0436	17.7426
390004	19.2277	20.3204	20.0557	19.8647
390005	17.3506	16.9472	19.0218	17.7359
390006	20.2959	21.1786	21.7867	21.0548
390007	21.7506	21.3839	*	21.5715
390008	17.8297	18.2743	19.5439	18.5382
390009	20.6507	20.6241	22.5580	21.2847
390010	17.5127	17.3335	18.1275	17.6598
390011	18.1717	18.3257	18.2751	18.2595
390012	20.6523	21.0610	22.2060	21.3101
390013	19.2698	19.6562	20.2186	19.7244
390015	13.1337	13.7352	14.3138	13.7169
390016	16.9892	17.1133	17.4931	17.1968
390017	16.7493	18.6113	18.5869	17.9293
390018	21.3626	19.0279	20.0672	20.1854
390019	16.7848	17.7258	18.7609	17.7608
390022	21.5064	24.8468	25.2980	23.8721
390023	21.8270	22.1044	23.9246	22.7927
390024	24.9437	25.4606	27.7643	26.0343
390025	15.6155	15.5523	14.0077	15.0571
390026	22.3902	22.9718	23.6317	23.0154
390027	26.8878	29.5940	29.4334	28.6169
390028	22.7700	23.6571	22.7820	23.0704
390029	21.5729	21.2661	24.4753	22.2475
390030	17.9580	18.6887	18.9121	18.5104
390031	19.2755	18.8162	19.2040	19.0999
390032	17.8041	21.5105	18.5545	19.2157
390035	20.2029	22.3591	21.9325	21.4746
390036	19.9880	19.7671	20.2103	19.9884
390037	21.0616	20.4263	19.9175	20.4619
390039	17.1046	17.5300	17.6181	17.4169
390040	15.9612	16.6876	17.4451	16.6853
390041	19.8080	20.4397	19.6159	19.9368
390042	22.7693	22.5775	22.0668	22.4719
390043	17.2607	17.4764	17.6739	17.4691
390044	20.2813	20.9831	21.3382	20.8726
390045	18.5574	19.4677	20.2107	19.4227
390046	20.7303	21.7445	21.3960	21.2868
390047	27.6661	26.9709	*	27.3457
390048	19.0920	19.7992	18.9776	19.2752
390049	21.1217	22.1586	22.8196	22.0220
390050	22.8808	22.2639	24.9156	23.2311
390051	25.7910	28.1385	*	26.8617
390052	20.9306	20.1195	21.2729	20.7554
390054	17.8852	18.4975	19.4686	18.5971
390055	24.2211	23.4017	25.7327	24.4723
390056	17.7858	19.3901	21.4121	19.5072
390057	20.2059	20.2395	21.6693	20.6975
390058	19.7379	20.3520	20.7930	20.2983
390061	21.2392	23.8722	22.8728	22.6127
390062	16.6721	17.3750	17.4710	17.1692
390063	20.0125	19.4965	20.1696	19.9019
390065	19.9361	20.0473	20.2930	20.0884
390066	19.8539	18.9296	19.0132	19.2529

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
390067	20.9688	20.8162	21.9885	21.2544
390068	18.3158	19.1109	21.6408	19.5148
390069	19.6466	*	*	19.6466
390070	16.1988	21.8549	22.7909	20.2250
390071	15.7165	16.0100	18.9416	16.7655
390072	16.3133	16.9232	16.9445	16.6922
390073	20.5581	21.2623	22.2703	21.3817
390074	18.4806	18.3093	19.7446	18.8130
390075	17.9840	18.7695	19.5840	18.6669
390076	20.2475	21.3290	19.7719	20.4342
390078	19.2089	19.0156	20.6483	19.5808
390079	18.3312	18.9269	19.5982	18.9583
390080	18.8028	21.4707	22.2449	20.7685
390081	24.8351	24.7461	25.6575	25.0775
390083	*	*	26.1660	26.1660
390084	16.4026	20.2529	17.0197	17.7133
390086	18.5265	18.3563	19.7645	18.9070
390088	23.6173	23.9506	*	23.7777
390090	21.6437	21.3759	20.5433	21.2027
390091	18.1569	18.3770	19.0355	18.5125
390093	17.7171	18.4442	20.0135	18.7217
390095	16.3357	16.6930	17.9697	16.9815
390096	19.1171	22.4382	22.2974	21.1662
390097	23.5963	25.2845	24.7853	24.5092
390100	20.7859	20.9263	21.1186	20.9469
390101	17.9499	18.5039	19.0180	18.4836
390102	19.0461	21.5496	19.3111	19.9785
390103	18.4312	18.8667	20.4422	19.2092
390104	15.9008	16.3255	16.2440	16.1553
390106	16.6666	16.8439	17.4747	16.9857
390107	19.5178	20.9841	20.6024	20.3811
390108	21.0899	21.3142	22.0444	21.4659
390109	16.4597	16.5299	17.4540	16.8127
390110	21.5282	21.6464	21.6005	21.5915
390111	27.5193	33.3971	27.1429	29.3913
390112	14.9427	15.0065	14.8634	14.9388
390113	19.1945	19.3634	19.9496	19.4908
390114	19.6295	20.9533	19.8004	20.1209
390115	23.3461	21.4287	22.3545	22.3386
390116	21.4877	21.3671	22.6783	21.8481
390117	17.9393	18.0769	18.9764	18.3315
390118	18.3440	18.9507	17.2668	18.1975
390119	18.2951	18.8815	19.3946	18.8604
390121	20.8780	19.1315	20.6253	20.2089
390122	17.1902	17.7734	15.5438	16.7430
390123	20.8344	21.3974	21.8897	21.3699
390125	16.7983	17.5446	17.0975	17.1374
390126	20.6498	*	*	20.6498
390127	21.7724	22.4555	22.8787	22.3758
390128	19.6792	19.3165	19.9764	19.6532
390130	17.7049	18.3695	18.5519	18.2059
390131	16.0986	19.2096	19.1931	18.1205
390132	21.1931	22.8414	24.1878	22.7048
390133	23.3489	24.7561	24.1590	24.0369
390135	21.5782	22.1905	22.2501	22.0004
390136	16.9737	20.6286	16.8505	18.1580
390137	17.5687	18.5397	19.4769	18.4683
390138	19.6212	20.6936	20.7726	20.3703
390139	24.4515	23.9757	24.8347	24.4216
390142	26.8086	28.8877	28.4680	28.1212
390145	20.3731	20.4228	20.4964	20.4300
390146	18.7922	18.6505	20.1788	19.1967
390147	20.9651	21.2492	21.7600	21.3199
390150	20.7294	20.3155	20.8970	20.6500
390151	21.6000	22.5206	23.6072	22.6096
390152	20.3353	19.4017	20.2581	19.9941

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
390153	23.7013	22.9707	23.9039	23.5281
390154	17.4036	16.7052	17.8774	17.3537
390156	21.8498	22.6398	24.0034	22.7950
390157	19.6578	19.1783	20.2647	19.6975
390160	21.4810	19.4463	19.4793	20.0709
390161	16.4799	*	*	16.4799
390162	21.4095	21.9188	21.3379	21.5605
390163	16.8013	17.7564	18.1831	17.5889
390164	24.6765	24.9750	26.1698	25.2621
390166	19.0405	19.7978	19.8899	19.5577
390167	19.8973	*	*	19.8973
390168	18.7400	18.8863	19.6875	19.1127
390169	20.2382	22.0547	22.7920	21.7176
390170	26.5891	24.7973	*	25.6898
390173	18.5370	18.6613	18.8265	18.6759
390174	25.4189	25.3307	26.3891	25.6959
390176	17.8740	20.8368	21.7650	20.0495
390178	16.6993	17.0534	17.1142	16.9526
390179	21.6901	21.8593	21.5792	21.7082
390180	25.7074	26.5541	26.7743	26.3551
390181	19.4654	19.3832	18.8681	19.2465
390183	17.8306	17.9848	17.4535	17.7535
390184	20.8060	20.9349	21.1941	20.9693
390185	18.8798	20.3877	20.3301	19.8556
390189	20.0889	20.3338	19.6186	20.0014
390191	16.3240	17.2270	17.1919	16.8998
390192	17.4537	17.6597	16.6469	17.2541
390193	16.7874	18.1209	17.3804	17.3866
390194	20.7953	21.2689	21.0549	21.0283
390195	24.6855	24.1793	24.2891	24.3890
390197	19.2690	20.7998	22.1974	20.7901
390198	15.9721	15.8833	16.6803	16.1535
390199	17.0515	17.3865	17.7782	17.3993
390200	15.1399	15.4012	18.2456	16.2785
390201	20.6296	20.3533	21.3291	20.7767
390203	20.9432	21.4989	22.4685	21.6448
390204	20.1779	22.9616	22.7282	21.9570
390206	18.4027	*	*	18.4027
390209	17.4792	18.7059	16.8200	17.6370
390211	17.8638	18.4213	19.4552	18.6187
390213	18.8555	19.1553	20.1152	19.3527
390215	20.7084	21.2032	23.5953	21.7981
390217	19.1406	19.9837	19.7578	19.6158
390219	18.8292	19.6226	20.1311	19.5227
390220	18.7178	17.7916	22.7617	19.7037
390222	21.5739	22.1548	22.7491	22.1668
390223	23.6482	22.1775	18.9493	21.4503
390224	15.3015	13.7518	17.2173	15.1752
390225	18.6125	18.7290	19.0364	18.7963
390226	21.8268	21.8481	22.8588	22.1457
390228	19.4083	19.8180	19.6212	19.6177
390231	22.7544	19.4798	21.0757	20.9857
390233	19.4887	20.2309	20.5800	20.1134
390235	25.0857	21.4200	19.9925	22.7713
390236	16.2397	17.8735	19.1427	17.7118
390237	19.5230	22.3011	21.7847	21.1302
390238	17.8211	17.1055	18.1956	17.6820
390244	15.4611	15.6402	14.2136	15.1054
390245	26.0194	24.5076	*	25.2650
390246	18.9733	25.0556	22.3892	21.9107
390247	20.9526	21.2151	*	21.0479
390249	12.7920	13.1657	14.1062	13.3677
390256	23.2734	22.2773	22.3540	22.6670
390258	21.9207	22.6852	23.8318	22.8365
390260	21.9509	21.5982	*	21.7740
390262	18.2379	*	18.8942	18.5346

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
390263	20.6855	20.3796	20.6348	20.5647
390265	20.3580	20.4950	20.4760	20.4411
390266	17.1666	17.1966	17.6223	17.3305
390267	21.2974	19.2665	20.2424	20.3797
390268	21.3486	22.0909	22.2046	21.8827
390270	19.0925	19.2074	20.7957	19.6567
390278	18.2865	17.7176	18.5776	18.2038
390279	14.3241	14.8655	15.8080	14.9814
390283	*	22.5490	*	22.5489
390284	*	34.3904	*	34.3902
390285	*	*	29.1270	29.1270
390286	*	*	22.9746	22.9746
390287	*	*	30.3252	30.3252
390288	*	*	26.9662	26.9662
390289	*	*	22.8963	22.8963
390290	*	*	30.5037	30.5037
390291	*	*	20.0272	20.0272
390293	*	*	23.5285	23.5284
400001	9.9463	10.5757	10.7531	10.4326
400002	10.1417	13.0494	13.3684	12.2030
400003	10.8821	12.4078	11.2726	11.5031
400004	8.9864	8.5648	9.0781	8.8776
400005	9.5632	7.7432	9.7802	8.9053
400006	10.3444	10.1048	10.4988	10.3215
400007	6.4490	8.0174	8.1974	7.5138
400009	8.4207	8.8650	8.7341	8.6758
400010	10.6518	10.8011	9.1359	10.1542
400011	7.4979	8.5426	8.6252	8.2277
400012	8.2412	8.4728	8.6538	8.4546
400013	8.4579	9.2624	9.8197	9.2598
400014	9.5235	9.4798	10.2712	9.7458
400015	10.9505	14.4076	15.5827	13.3370
400016	13.2756	13.3922	13.7001	13.4570
400017	8.6421	9.2577	9.9167	9.2527
400018	10.4557	10.6208	10.5583	10.5484
400019	10.4332	10.8940	12.1251	11.2505
400021	10.6988	12.1434	12.7462	11.9145
400022	11.5861	12.2199	13.0915	12.2933
400024	7.8984	9.2409	9.0826	8.6750
400026	5.6454	5.8335	7.4280	6.2931
400027	9.5899	*	*	9.5899
400028	8.8597	9.1794	8.9567	8.9909
400031	8.2660	*	*	8.2660
400032	10.5498	10.0448	10.1898	10.2599
400044	11.9704	11.9486	12.8671	12.2011
400048	9.1701	15.1405	11.5104	11.4186
400061	12.4493	13.0988	10.3664	11.9076
400079	*	9.7203	8.7218	9.1657
400087	9.5097	9.8534	8.6480	9.3956
400094	8.9116	7.9187	9.4600	8.7591
400098	9.3308	9.7791	10.4312	9.8607
400102	9.8536	9.9903	8.5290	9.4812
400103	11.2069	11.5359	11.8454	11.4791
400104	11.0672	10.7292	7.9552	10.3151
400105	9.3049	9.0556	10.6028	9.5117
400106	9.3123	9.2187	9.8694	9.4766
400109	10.9826	11.8760	12.2080	11.7082
400110	10.3326	10.5277	10.7228	10.5456
400111	9.5583	10.9665	12.3311	11.0412
400112	10.1755	10.8694	11.0634	10.7058
400113	9.2238	8.3168	9.3000	8.9540
400114	9.0496	7.0510	9.9477	8.5888
400115	9.8244	8.5487	7.2203	8.5322
400117	10.2295	10.8756	11.3351	10.8116
400118	9.4398	11.4051	11.4317	10.7997
400120	9.5274	10.6584	10.9315	10.3832

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
400121	7.8052	9.8322	8.7584	8.8340
400122	8.1911	7.6413	9.1638	8.3405
400123	7.8099	10.2367	10.9047	9.6438
400124	12.0999	12.2452	12.7323	12.3713
400125	*	10.2056	10.5997	10.3924
410001	23.2808	23.1738	22.4972	22.9875
410004	22.4801	21.0638	23.5408	22.3806
410005	23.1444	22.7170	24.0086	23.2835
410006	23.3968	23.8700	22.8959	23.3695
410007	22.1452	23.1325	24.9846	23.3527
410008	23.0662	24.9726	24.4792	24.1739
410009	24.4899	24.3895	24.3760	24.4190
410010	26.9813	28.4589	29.7315	28.3794
410011	25.2926	26.1183	27.4880	26.2586
410012	24.5811	24.1695	26.4570	25.0414
410013	24.5122	24.8800	25.3688	24.9319
420002	19.4845	20.7804	22.6182	20.9552
420004	19.7968	20.9588	22.4680	21.0257
420005	17.3510	17.9694	17.8202	17.7153
420006	18.3439	19.1760	18.7153	18.7343
420007	18.2096	18.6456	19.0199	18.6081
420009	18.5456	19.9586	21.2566	19.9500
420010	17.1184	18.0252	19.3267	18.2127
420011	16.5664	18.0970	16.7523	17.1112
420014	16.6065	18.0519	19.0455	17.8775
420015	18.8411	20.1164	20.8736	19.8858
420016	15.6241	15.5485	16.6448	15.9623
420018	19.7367	21.8775	20.7779	20.7419
420019	16.9990	17.1726	19.0199	17.6834
420020	20.9449	20.3193	20.5801	20.5993
420023	19.4855	20.4053	20.8600	20.2789
420026	20.3476	21.8749	23.3072	21.9035
420027	18.8457	19.2594	19.7322	19.2883
420030	19.1453	20.6448	22.5159	20.8443
420031	14.1855	8.2516	15.3605	11.6044
420033	21.7279	23.1303	23.7974	22.8884
420036	17.6136	21.3222	19.8285	19.5069
420037	21.7908	22.7099	23.5244	22.7289
420038	17.6726	18.6568	19.9829	18.7495
420039	15.8385	18.3017	18.0055	17.3738
420043	19.4521	19.7570	19.6834	19.6347
420048	18.4367	18.8070	20.5531	19.2732
420049	17.5854	19.4049	20.1765	19.0818
420051	19.5001	19.1555	19.8549	19.5061
420053	16.9599	18.1657	19.0780	18.0364
420054	18.2702	20.2574	20.2275	19.5600
420055	19.2048	16.8717	18.6782	18.0932
420056	14.8695	15.1835	16.5491	15.4839
420057	15.9849	20.5266	22.1312	19.6895
420059	15.8160	17.1483	18.2093	17.0936
420061	16.5555	17.3543	17.7047	17.2228
420062	17.8205	21.7469	20.9032	20.1974
420064	16.7227	16.0794	19.7067	17.5583
420065	19.6902	19.9435	19.2150	19.5969
420066	15.1804	18.0042	19.5366	17.5193
420067	18.8610	19.7824	20.8524	19.8567
420068	18.5030	18.5481	20.2580	19.1326
420069	17.0788	18.1298	18.9017	18.0129
420070	18.0057	17.3876	19.2186	18.1995
420071	19.4482	20.3902	20.1897	20.0146
420072	13.8550	15.0158	18.2531	15.7212
420073	19.1604	19.9986	20.2697	19.8499
420074	16.9292	18.0967	18.1839	17.6249
420075	14.2931	12.8158	15.0132	14.0442
420078	20.7317	21.9082	22.7156	21.7962
420079	20.8639	21.0874	21.3177	21.0994

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
420080	22.3443	21.9968	23.2871	22.5856
420082	20.4653	21.7210	22.8516	21.6895
420083	20.1472	22.6376	24.4499	22.3616
420085	19.9603	21.6791	22.0071	21.2571
420086	25.7179	20.2878	23.5303	23.0156
420087	19.1403	19.8388	20.8217	19.9506
420088	17.1938	19.9919	21.8979	19.5872
420089	20.2537	20.5360	21.3954	20.7386
420091	18.8687	20.3092	21.8367	20.2654
420093	17.4689	18.3902	19.1299	18.3060
420095	*	*	33.4632	33.4634
420096	*	*	26.4863	26.4864
430004	18.5438	19.6344	19.2737	19.1454
430005	16.3059	16.4560	17.3400	16.6979
430007	14.1078	14.6331	15.1494	14.6319
430008	17.6640	18.1323	18.5234	18.0977
430010	17.1766	19.8191	16.5750	17.7180
430011	16.9848	17.4750	18.3648	17.6074
430012	17.2775	17.6997	19.2921	18.0907
430013	18.1338	18.4817	18.8978	18.5085
430014	16.8925	20.2387	20.9118	19.1361
430015	18.0019	18.2875	18.8998	18.3871
430016	19.4759	20.8850	22.7585	20.9797
430018	14.8854	16.2244	15.9424	15.6759
430022	13.4905	14.5118	14.0661	13.9980
430023	12.2331	16.2164	16.7850	14.8010
430024	15.4709	16.1801	17.4816	16.3448
430027	19.1461	20.2591	20.8666	20.0818
430028	18.2312	17.1577	18.2829	17.8947
430029	16.6500	17.6986	17.4932	17.2971
430031	13.1258	12.4660	13.2105	12.9278
430033	15.3003	17.3652	18.3978	16.9036
430034	15.4064	14.2491	13.8535	14.4964
430036	13.6967	15.6258	16.7827	15.2466
430037	16.5368	18.1293	18.7009	17.7855
430038	13.7167	18.4078	*	15.7522
430040	13.6745	14.4509	14.7860	14.2554
430041	13.1936	14.8816	*	14.0079
430043	13.6908	14.9949	17.0193	15.1103
430044	18.4970	21.0823	*	19.6187
430047	17.4956	17.9823	17.5377	17.6691
430048	18.3524	18.7602	19.0261	18.7260
430049	15.5381	15.2237	14.9025	15.2275
430051	17.0574	18.8070	18.8697	18.2650
430054	14.7251	14.8003	15.0101	14.8472
430056	11.7627	10.3697	14.1914	11.9246
430057	15.4390	17.2805	18.8777	17.1911
430060	9.0358	10.0176	9.7678	9.6151
430064	14.4367	14.2184	13.8666	14.1634
430066	14.3557	15.6660	14.5957	14.8566
430073	16.1133	15.3776	16.5112	15.9989
430076	12.7608	13.9883	15.2453	13.9494
430077	19.3012	19.8558	20.4361	19.8699
430079	13.6836	14.1815	14.4154	14.0719
430089	17.8908	17.9790	17.5100	17.7870
430090	21.5239	21.5974	23.5180	22.2918
430091	19.2146	18.1567	21.6239	20.0217
430092	*	21.3807	19.7644	20.5428
430093	*	19.5013	23.3009	21.3125
440001	14.8713	15.5897	17.2282	15.8569
440002	19.1498	20.3740	21.4299	20.3167
440003	18.3658	19.3042	20.3756	19.3464
440006	19.6021	21.4055	23.1483	21.3134
440007	12.1230	14.8959	14.0612	13.6386
440008	17.2848	18.8994	20.3303	18.7894
440009	17.8424	17.4831	18.4068	17.9080

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
440010	19.9829	16.3283	13.3692	16.2699
440011	17.6948	18.3375	19.3165	18.4706
440012	15.9837	19.5739	19.8949	18.4979
440014	15.9195	16.1143	15.0656	15.7064
440015	18.2632	22.0659	21.6106	20.5435
440016	15.4097	16.2964	14.6142	15.3378
440017	19.6215	20.4563	20.4705	20.1721
440018	16.4115	17.4995	18.1620	17.3534
440019	20.0416	21.5402	22.8463	21.4594
440020	18.1154	17.8879	20.2189	18.7233
440022	15.8459	*	*	15.8461
440023	15.4721	16.7837	15.6603	15.9134
440024	18.4432	18.4046	18.4276	18.4251
440025	15.8784	16.3140	17.0997	16.4428
440026	23.0550	23.2566	25.6490	23.8993
440029	19.4326	20.7050	22.2889	20.8403
440030	16.2941	16.9925	17.6297	17.0242
440031	15.5432	17.0211	17.2555	16.5726
440032	13.9775	13.8140	13.9784	13.9249
440033	14.5304	13.7328	16.4679	14.8744
440034	19.5470	20.0309	21.1672	20.2667
440035	18.9026	19.3034	20.4168	19.5344
440039	19.9439	21.6536	22.4158	21.3378
440040	16.3740	16.9275	17.6781	16.9632
440041	14.6621	14.9545	14.6684	14.7645
440046	18.1654	19.3229	20.5562	19.3415
440047	16.6646	17.8092	18.7469	17.7021
440048	19.4498	21.4993	21.6132	20.8900
440049	17.9292	18.7967	19.6920	18.7945
440050	19.1328	18.2511	19.7915	19.0510
440051	13.1901	16.0421	17.7067	15.5027
440052	16.6541	19.8075	18.6589	18.2811
440053	18.5515	19.6494	21.5253	19.8982
440054	13.8716	13.3967	15.2154	14.1791
440056	15.9821	16.2742	20.4903	17.3863
440057	12.7925	13.7257	14.4363	13.6135
440058	18.8118	19.1878	20.7722	19.5723
440059	18.5418	19.6018	20.8882	19.6895
440060	18.0586	19.7916	20.7628	19.4260
440061	14.9708	22.5525	16.9234	17.8112
440063	19.3222	19.8371	18.8072	19.3003
440064	17.7652	18.9809	18.2678	18.2991
440065	18.5825	18.8296	19.2282	18.8924
440067	16.2811	17.2397	18.2973	17.2997
440068	19.4695	19.3668	19.5428	19.4608
440070	13.7035	14.0437	18.0064	15.1918
440071	17.0186	19.7836	*	18.2110
440072	17.5995	19.1522	20.0691	18.8963
440073	19.1714	19.5554	19.6290	19.4550
440078	15.0849	16.0188	17.1645	15.9789
440081	18.3587	19.3454	17.2905	18.2386
440082	22.2857	22.6855	22.5590	22.5073
440083	14.8525	13.7423	13.7630	14.1806
440084	13.4378	13.7731	13.8085	13.6799
440091	19.6114	20.1065	20.1359	19.9669
440100	13.8437	14.7113	15.9969	14.8524
440102	14.3510	14.5500	16.0783	14.9840
440103	20.3052	18.6990	*	19.4877
440104	22.4403	22.6754	21.7135	22.2610
440105	16.7131	17.1172	18.1375	17.2950
440109	16.0446	17.7443	17.6399	17.0830
440110	21.1716	17.4816	18.4998	18.8996
440111	23.2425	23.2254	23.2111	23.2266
440114	14.4997	15.0036	18.5327	16.0830
440115	17.4514	18.5457	18.7054	18.2287
440120	17.2384	16.3115	19.8997	17.7817

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
440125	15.6588	19.4115	20.0599	18.4060
440130	17.8223	17.4857	19.0905	18.1589
440131	15.5048	16.1214	19.9883	17.1760
440132	16.6553	16.8871	17.9186	17.1418
440133	21.5313	23.0891	22.2257	22.2659
440135	19.2010	22.2005	22.5452	21.4251
440137	14.5632	15.0070	15.3530	14.9670
440141	13.5308	15.9429	17.6819	15.3875
440142	15.7287	16.8855	17.1483	16.5303
440143	17.7821	18.2061	18.6844	18.2206
440144	17.6415	18.3859	18.8127	18.2853
440145	17.0608	18.3948	18.3850	17.9146
440147	21.4304	26.1464	25.3766	24.0818
440148	19.2435	19.4598	19.3769	19.3574
440149	16.6923	18.4281	19.8304	18.3721
440150	20.1411	20.3006	21.2942	20.5974
440151	17.4248	18.3928	19.8977	18.5439
440152	21.0287	22.7664	21.7382	21.7452
440153	16.7769	16.5716	18.1781	17.1656
440156	29.5557	21.7577	21.9374	23.7510
440157	16.9265	18.4249	15.5316	17.0209
440159	17.7158	20.9371	21.4914	19.6375
440161	21.8013	22.8816	23.6805	22.8012
440162	14.7637	15.5534	19.8075	16.5656
440166	19.6684	19.2159	19.6632	19.5183
440168	18.6535	19.1509	21.1947	19.6498
440173	18.6402	19.1812	21.0284	19.6315
440174	17.3294	18.0865	19.3966	18.2367
440175	20.0802	18.5186	19.9022	19.4845
440176	18.0294	19.2208	19.8448	19.0126
440180	19.7773	20.2184	20.2057	20.0681
440181	16.4878	17.7709	19.0915	17.6551
440182	17.7487	19.7094	18.1953	18.4985
440183	22.7067	21.3465	22.2401	22.0840
440184	17.2037	16.8880	18.6890	17.3933
440185	19.3870	21.2188	21.1226	20.6133
440186	19.3948	19.7983	20.8600	20.0053
440187	18.9713	17.5872	18.3729	18.3113
440189	*	18.5252	22.2555	20.3772
440192	19.0839	19.1705	19.1976	19.1524
440193	19.0811	18.6999	19.9078	19.2111
440194	19.8682	22.4562	21.9609	21.4700
440197	21.9618	21.8503	22.5282	22.1263
440200	17.9575	19.8078	18.7302	18.8422
440203	18.3400	16.2861	16.9819	17.1896
440206	16.4429	*	*	16.4428
440210	11.0218	11.9815	12.7622	11.9731
440211	14.8972	*	*	14.8972
440212	17.0685	*	*	17.0686
440213	19.5760	*	*	19.5758
440214	*	28.0285	*	28.0287
440215	*	22.2928	*	22.2928
440217	*	*	19.2834	19.2834
450002	21.3749	21.4836	21.5141	21.4583
450004	16.6723	16.7850	15.9452	16.5074
450005	18.3600	16.6396	16.6354	17.2368
450007	16.9681	19.1910	18.0269	18.0419
450008	17.0832	17.6582	19.3745	18.0076
450010	16.5001	17.6677	19.8998	18.3388
450011	17.1942	20.8102	20.2963	19.3771
450014	17.9495	17.5815	19.8846	18.4700
450015	18.9895	21.6773	22.9820	21.1074
450016	18.4463	18.3456	19.1522	18.6447
450018	21.4788	23.2293	21.9921	22.1397
450020	17.8415	19.1153	18.4642	18.4858
450021	23.0843	23.3630	23.7663	23.4150

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
450023	16.0831	17.6360	19.2808	17.6838
450024	17.3518	18.5985	19.5584	18.5411
450025	17.0004	*	*	17.0004
450028	18.8764	19.1658	19.5905	19.2141
450029	17.4716	17.7425	19.9505	18.4194
450031	22.2222	29.6945	29.6772	27.1869
450032	17.3317	14.6530	20.8525	17.3455
450033	19.7437	21.0222	21.3766	20.7326
450034	19.6721	18.8823	19.5233	19.3523
450035	20.0951	20.3599	20.3146	20.2513
450037	19.5411	19.9140	19.6532	19.7050
450039	19.8143	19.7176	20.4660	19.9969
450040	16.8534	19.6370	24.8621	21.1896
450042	19.8921	18.8357	20.6041	19.7840
450044	24.7961	21.0909	23.4476	22.9976
450046	18.6536	17.3631	20.2917	19.2568
450047	13.4486	16.9028	15.9525	15.2979
450050	14.7669	17.7209	19.1390	17.0907
450051	21.0236	21.1008	23.0010	21.6800
450052	13.8881	15.5890	20.3702	16.6434
450053	17.0467	17.2781	19.3347	17.8122
450054	22.8960	19.2431	23.0492	21.9091
450055	15.0433	15.8526	16.4789	15.8195
450056	21.8436	21.8605	22.5341	22.0863
450058	18.0967	18.6172	20.0424	18.9513
450059	15.2168	19.8240	21.4873	18.7159
450063	14.3815	12.7211	15.1779	13.9190
450064	17.4093	19.7682	21.3929	19.5099
450065	21.4934	23.3797	23.8471	22.8509
450068	22.8998	23.3495	22.5626	22.9345
450072	19.0111	18.0307	20.0134	19.0500
450073	17.1002	16.5942	23.7700	19.3382
450078	11.7265	13.2820	13.9324	12.9289
450079	21.0518	20.6483	22.0609	21.2553
450080	17.4553	18.6212	19.8414	18.6088
450081	16.3448	17.5737	19.0276	17.6152
450082	16.1585	16.8677	18.0688	17.0258
450083	21.5884	23.3754	20.7446	21.8692
450085	18.3602	20.0085	17.5001	18.5675
450087	22.0273	21.9320	23.4141	22.4951
450090	15.0939	15.5796	15.6090	15.4353
450092	16.8260	17.9520	17.2058	17.3255
450094	21.3158	23.2863	25.2158	23.1854
450096	17.8813	18.6802	19.4430	18.6508
450097	19.5723	19.7187	20.7653	20.0316
450098	20.5754	19.0454	19.8469	19.8192
450099	19.2258	20.4181	19.3493	19.6218
450101	17.1330	17.7928	17.6368	17.5088
450102	18.6707	19.8793	21.4361	19.9466
450104	16.6744	17.0821	17.8219	17.1908
450107	25.1986	24.1094	24.5034	24.5948
450108	15.6324	15.2797	17.9596	16.3778
450109	13.8127	10.5973	18.1085	13.5597
450110	19.5821	*	*	19.5821
450111	19.6350	21.4908	*	20.6248
450112	16.0441	18.1026	17.9624	17.4193
450113	20.9777	20.8306	20.7782	20.8679
450118	17.9053	*	*	17.9053
450119	20.2853	20.2030	20.1436	20.2055
450121	20.4641	21.9198	22.0485	21.4762
450123	15.7618	14.1755	17.5051	15.6216
450124	22.7480	22.5208	22.9853	22.7584
450126	21.7233	21.4789	22.9423	22.0532
450128	18.2184	18.1446	18.7067	18.3642
450130	20.4156	18.9211	20.2613	19.8921
450131	19.2589	17.4168	18.1401	18.2336

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
450132	18.1713	21.8089	20.8908	20.3184
450133	23.6366	26.0763	24.5319	24.7178
450135	21.0306	20.4068	21.7038	21.0684
450137	22.4590	23.4346	22.8653	22.9109
450140	20.2280	17.3370	19.6205	19.0889
450143	14.5270	15.0871	17.8206	15.8389
450144	18.1121	17.4309	21.9135	19.1672
450145	15.6078	16.1895	18.0437	16.6039
450146	17.8572	15.5030	17.4391	16.8224
450147	18.9363	19.0477	20.3019	19.4231
450148	18.6758	20.4923	21.4982	20.3512
450149	19.7521	21.7219	22.6138	21.3072
450150	16.3719	17.8612	17.8804	17.3567
450151	15.2906	16.4209	16.3279	16.0117
450152	18.0061	17.7265	19.6105	18.4659
450153	19.4419	18.6514	20.9651	19.5973
450154	13.8731	13.9119	16.8748	14.8870
450155	11.5841	13.3456	20.2582	14.4198
450157	15.6371	15.3083	16.8569	15.9683
450160	16.6533	10.6852	18.7780	14.2553
450162	20.9560	21.9218	20.5032	21.1178
450163	17.5403	17.8028	19.7675	18.3370
450164	16.9741	17.7180	18.7103	17.7836
450165	13.9218	17.3283	16.1010	15.6645
450166	11.4772	11.0541	12.6627	11.7456
450169	13.1990	*	*	13.1990
450170	14.2997	14.3234	15.8525	14.8194
450176	16.9674	17.2576	19.2397	17.7972
450177	14.9241	15.2419	16.4503	15.5457
450178	17.8508	16.0280	15.8597	16.5717
450181	15.5622	18.6936	18.3600	17.5713
450184	21.1263	20.0821	22.7744	21.3241
450185	14.0714	11.5228	13.2015	12.8206
450187	16.6945	18.5053	20.8105	18.6152
450188	14.3938	15.1954	16.9800	15.5696
450191	20.1222	20.9512	20.5883	20.5559
450192	20.3795	21.2497	20.8315	20.8154
450193	23.1963	23.1639	25.1215	23.8401
450194	20.5187	20.7745	20.7152	20.6727
450196	17.1955	17.8993	21.1226	18.6516
450200	18.7387	19.2228	19.6496	19.1969
450201	16.9908	17.1463	18.0646	17.4134
450203	20.6712	19.3978	19.7978	19.9564
450209	19.0811	20.0140	21.3218	20.0963
450210	13.9758	16.3470	16.8532	15.7918
450211	17.9857	18.8114	18.7305	18.5258
450213	17.7631	19.0651	19.3440	18.7353
450214	19.0475	20.5070	21.3448	20.2748
450217	12.8457	12.7647	13.1840	12.9276
450219	15.3976	17.6884	18.5534	17.2282
450221	16.3700	15.2120	16.2308	15.9182
450222	20.3129	19.8967	23.2779	21.1824
450224	24.9046	20.1579	20.1723	21.4823
450229	16.4503	16.7853	17.0346	16.7617
450231	19.1564	19.1746	20.7709	19.7438
450234	16.1945	16.3003	17.9478	16.9370
450235	15.2332	16.3115	17.0143	16.2190
450236	16.6703	16.4957	18.4551	17.2049
450237	20.7930	19.0325	21.6497	20.5284
450239	17.1308	17.8401	18.8416	17.9241
450241	12.5675	16.4240	16.6046	14.9426
450243	11.9099	13.6416	11.2035	12.2464
450246	16.5478	16.7959	22.7940	18.4445
450249	12.0302	11.7658	10.6467	11.4953
450250	10.2844	13.6787	18.3361	13.3340
450253	12.2402	13.2177	14.5492	13.3367

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
450258	16.0466	16.7337	17.0724	16.6100
450264	13.8929	14.5956	17.2825	15.2193
450269	12.3594	12.7717	12.2970	12.4710
450270	12.8381	14.4792	13.8881	13.6870
450271	16.6319	16.7831	17.9570	17.1607
450272	19.9331	18.4344	20.5888	19.6562
450276	13.1155	14.0745	14.0779	13.7681
450278	14.8291	15.2950	14.3931	14.8081
450280	22.2984	22.2936	22.2648	22.2845
450283	14.5664	15.1950	15.8224	15.2295
450288	16.2502	18.8935	17.4817	17.4808
450289	20.3104	20.3460	22.4656	21.0290
450292	16.9693	20.5335	21.1511	19.3669
450293	16.0132	16.2721	16.4077	16.2364
450296	21.6000	22.3430	21.5998	21.8526
450299	21.5672	*	21.2754	21.4132
450303	12.4582	12.8996	14.3353	13.2442
450306	13.8216	14.2047	13.6333	13.8808
450307	16.4622	17.0691	17.6757	17.0817
450309	13.1480	13.3771	16.0363	14.2012
450315	22.8140	21.4684	23.8151	22.6579
450320	20.0946	20.6596	24.8602	21.5440
450321	13.1752	14.7344	17.2289	14.9366
450322	22.7667	29.1884	28.9834	26.4969
450324	17.7886	19.1692	20.9081	19.2343
450327	11.7511	13.3639	11.0983	11.9405
450330	18.9425	19.8066	21.0921	19.9853
450334	12.8051	13.8392	13.9812	13.5350
450337	17.1073	25.5708	*	20.0638
450340	17.6914	*	19.2611	18.4733
450341	18.9429	*	20.8814	19.8654
450346	17.5367	18.9475	19.2769	18.6527
450347	17.1099	19.3475	20.1899	18.8713
450348	13.9535	13.3585	15.0069	14.1063
450351	18.4116	19.3159	21.2842	19.6777
450352	18.7480	20.1871	21.2035	20.1227
450353	17.7539	16.0003	17.3274	17.0034
450355	11.9473	11.8933	12.8876	12.2285
450358	22.3235	23.0206	25.5767	23.5999
450362	15.8847	18.1983	18.7687	17.5865
450369	15.2233	15.3122	16.0667	15.5405
450370	12.6061	16.1369	18.7539	15.9177
450371	24.6339	16.0236	17.7591	19.2388
450372	20.0924	22.0746	21.4050	21.1434
450373	17.4183	17.9554	18.5716	17.9576
450374	13.6099	15.1750	15.0146	14.5995
450378	23.5789	23.4599	24.4143	23.8974
450379	22.7632	22.8756	25.1931	23.6182
450381	16.4166	16.7112	16.7237	16.6241
450388	19.2499	19.7408	20.7989	19.9913
450389	18.1797	18.8448	19.3156	18.7899
450393	20.2784	22.4992	21.4405	21.3365
450395	18.3768	18.0024	17.5236	17.9433
450399	15.7845	15.3491	16.3333	15.8319
450400	19.5379	18.6668	19.1345	19.0923
450403	20.1989	22.8430	24.7657	22.7036
450411	14.4832	15.1121	15.9165	15.1694
450417	13.4983	15.3591	15.2713	14.6933
450418	21.9161	21.9690	22.2511	22.0447
450419	20.6325	23.2551	22.9522	22.3158
450422	26.4848	28.0257	28.0395	27.5279
450423	22.7132	*	*	22.7132
450424	18.9741	18.7895	20.7634	19.5561
450429	13.8723	*	*	13.8722
450431	19.6304	22.0361	22.6766	21.4257
450438	19.5028	15.4553	21.0474	18.4017

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
450446	13.0986	20.7592	13.8011	15.2461
450447	18.0376	18.0377	19.7532	18.5828
450451	18.8948	18.2988	18.9519	18.7274
450457	24.7880	19.6569	*	21.9578
450460	15.1765	14.6523	15.9446	15.2519
450462	22.6212	22.1144	22.5413	22.4225
450464	13.2931	15.5908	15.8121	14.8193
450465	15.5650	15.4731	19.3928	16.5297
450467	10.6184	17.0004	18.9388	14.4801
450469	19.6269	22.1930	22.0389	21.2453
450473	19.9761	19.7148	18.3813	19.2637
450475	16.3404	16.9269	19.0010	17.4228
450484	16.8131	18.9825	19.5505	18.4862
450488	19.3457	19.2173	22.0927	20.2121
450489	9.9326	16.3584	17.8779	13.9861
450497	15.0886	16.2997	15.9654	15.7937
450498	13.8551	14.4713	15.9479	14.7991
450508	18.8069	19.0991	19.3274	19.0816
450514	21.3243	20.0144	20.7064	20.6957
450517	27.8815	14.3191	17.6011	18.7482
450518	19.8116	21.4873	20.7355	20.6380
450523	20.0792	21.0393	23.8270	21.6109
450530	22.8623	21.1634	21.8988	21.9395
450534	19.9376	20.1520	19.7410	19.9371
450535	19.6645	21.0513	21.5449	20.7286
450537	20.8438	20.1161	20.8849	20.6189
450539	16.4921	18.7559	19.3681	18.2066
450544	23.9283	23.6652	22.7282	23.5339
450545	19.5558	20.2823	21.0792	20.2860
450547	14.8248	18.1524	20.5049	17.8141
450551	16.9439	16.6237	16.1437	16.5621
450558	22.2574	20.7404	21.3116	21.4292
450563	19.9218	22.0708	21.9935	21.4039
450565	16.2652	17.3803	17.8058	17.1566
450570	18.9532	19.0336	*	18.9910
450571	17.5598	18.2784	19.5325	18.4467
450573	12.2502	17.3518	17.6157	15.5831
450574	14.5965	14.6128	14.8549	14.6891
450575	19.3925	22.5621	24.0386	22.1410
450578	15.4783	18.0925	17.2863	16.9084
450580	15.8321	16.7374	17.8224	16.7968
450583	15.6580	14.4411	15.9430	15.3488
450584	14.2321	14.6735	14.9237	14.6266
450586	14.3773	13.8248	14.7433	14.3053
450587	17.0230	18.0219	18.0014	17.6684
450591	17.8981	17.7795	18.6714	18.1275
450596	22.5420	21.6729	21.9445	22.0245
450597	17.0776	17.6179	19.0641	17.9259
450603	11.6442	23.5572	23.4924	18.9348
450604	16.4535	17.6582	18.7465	17.6322
450605	21.1400	19.4580	19.7400	20.0918
450609	15.9753	17.0986	14.1776	15.7466
450610	18.9924	21.5191	23.5626	21.7315
450614	17.9853	16.5754	*	17.2230
450615	14.8562	15.2956	15.0621	15.0692
450617	20.3387	20.8919	21.5004	20.9383
450620	15.8380	16.0987	16.4330	16.1476
450623	22.1950	23.1270	25.1122	23.4424
450626	18.1673	18.4349	20.5225	19.1158
450628	20.5611	18.6093	20.0411	19.7604
450630	21.6876	20.9605	23.1840	21.9334
450631	20.0417	21.6736	21.8940	21.1769
450632	11.7587	13.9147	15.1416	13.5343
450633	19.5183	19.4949	*	19.5064
450634	23.5333	22.9877	23.0470	23.1838
450638	23.1437	22.1704	23.8335	23.0423

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
450639	23.1936	21.6421	23.0496	22.6205
450641	16.5125	15.7578	15.3652	15.8807
450643	18.7054	16.8152	18.9088	18.1638
450644	23.6587	22.7721	24.5834	23.7084
450646	19.8274	19.1433	23.1240	20.5802
450647	24.7981	24.2763	25.0549	24.7111
450648	14.8488	15.0305	14.4884	14.7695
450649	16.4496	16.6577	16.8505	16.6612
450651	22.7664	22.7112	25.4679	23.6985
450652	13.4389	17.2445	*	14.7103
450653	18.1834	19.2349	20.2436	19.1660
450654	14.5258	14.5423	15.5858	14.8899
450656	17.6723	18.2606	18.5874	18.1828
450658	16.2657	17.2630	19.4139	17.5926
450659	22.2550	23.0108	22.9344	22.7256
450661	19.7160	18.9071	19.5504	19.3935
450662	18.2284	19.3152	20.7973	19.5367
450665	15.2015	16.1319	14.5158	15.2939
450666	20.3248	20.2549	*	20.2912
450668	20.6965	21.0972	21.2002	20.9938
450669	21.7632	21.6746	22.5150	22.0051
450670	16.8893	20.2632	19.7696	19.0807
450672	21.8559	21.4927	23.2623	22.2025
450673	13.9620	13.7005	14.9115	14.2386
450674	22.2796	22.2426	21.9624	22.1483
450675	22.4961	21.4479	23.3954	22.4703
450677	22.6839	20.6556	21.7366	21.6615
450678	23.2617	24.1301	25.1841	24.1797
450683	20.9143	22.8699	22.1965	21.9453
450684	19.7005	21.9962	22.2380	21.3152
450686	16.5661	16.4632	17.4746	16.8354
450688	19.6250	20.1831	21.7691	20.5644
450690	21.6578	22.4707	27.2399	23.4791
450694	17.4758	18.1872	18.5520	18.0935
450696	24.9636	*	*	24.9636
450697	18.8405	19.4949	19.4424	19.2742
450698	14.6680	15.4750	16.5111	15.5420
450700	14.6421	15.9050	14.2055	14.9219
450702	20.8223	21.3739	19.8094	20.6324
450704	20.9821	20.7987	18.1835	19.7101
450705	30.0116	22.1809	18.7138	22.5666
450706	21.2072	22.0884	22.4329	21.9400
450709	20.8889	22.1490	22.0123	21.7006
450711	19.8126	19.8581	20.8047	20.1736
450712	13.6240	15.9298	11.1086	13.3744
450713	20.8065	22.6986	23.6189	22.4743
450715	22.0413	22.5988	24.8068	23.2060
450716	20.5544	20.9074	20.8913	20.7944
450717	20.7192	20.6551	22.0243	21.1286
450718	19.6886	22.1765	23.0051	21.6764
450723	19.7563	20.8213	22.0633	20.9085
450724	20.3235	20.3706	23.3799	21.3424
450727	13.5458	17.9172	24.6125	17.9196
450728	17.5284	19.8879	14.9265	17.3299
450730	22.0819	23.0054	24.5952	23.2900
450733	20.7693	20.2199	21.9921	20.9887
450735	13.8767	*	*	13.8768
450742	22.7655	21.8392	22.8135	22.4714
450743	18.8937	19.6015	20.5017	19.6892
450746	12.7904	30.2657	14.6683	17.1933
450747	19.2585	20.3914	20.3870	20.0318
450749	16.2130	19.1678	18.7138	18.1992
450750	14.6914	13.8098	*	14.2686
450751	21.2198	19.9995	19.8170	20.4240
450754	16.0860	16.7145	17.8497	17.0113
450755	17.9904	19.8743	20.0667	19.3563

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
450757	13.8675	14.9434	15.6425	14.7901
450758	21.8669	19.0221	22.6196	21.1578
450760	17.4852	19.2225	20.4209	19.0477
450761	13.6152	15.7681	14.6511	14.6112
450763	18.2123	18.6092	18.9713	18.6032
450766	22.4348	23.3879	25.4057	23.7704
450769	14.5858	18.4163	17.9879	16.6578
450770	16.5458	19.0183	20.0632	18.5467
450771	22.4542	21.8268	21.6946	21.9479
450774	17.9964	16.2948	*	17.1404
450775	19.8897	21.3504	22.6526	21.2920
450776	15.7750	14.1720	13.4263	14.1832
450777	21.0682	19.0380	18.3119	19.5171
450779	21.4546	21.6642	22.6216	21.9593
450780	19.1498	19.0914	20.0824	19.4503
450785	18.4976	*	*	18.4975
450788	19.1463	19.6469	19.9817	19.6564
450794	18.2229	*	*	18.2229
450795	16.6494	22.5753	27.0250	21.6046
450796	16.5362	19.2059	26.8539	22.7324
450797	15.9188	16.4923	20.2356	17.4420
450798	9.4634	*	*	9.4634
450801	17.5669	17.9548	18.0598	17.8661
450802	19.9168	17.1435	18.2460	18.3472
450803	18.3767	21.6653	37.0925	26.9538
450804	19.4846	19.0893	20.5225	19.7061
450806	*	*	20.7906	20.7906
450807	11.3192	13.4306	18.4410	13.7054
450808	16.9915	17.4917	18.1728	17.5602
450809	20.0202	19.7899	21.9845	20.5837
450811	19.0961	19.9168	21.6115	20.3503
450813	15.9166	14.5392	15.3780	15.2272
450815	*	21.2741	*	21.2742
450819	*	16.5521	*	16.5521
450820	*	26.8348	24.6542	25.7074
450822	*	22.8556	24.8702	23.9136
450823	*	*	17.9756	17.9757
450824	*	*	25.7488	25.7488
450825	*	*	16.0793	16.0793
450827	*	*	20.1310	20.1309
450828	*	*	19.2902	19.2902
450829	*	*	14.7121	14.7122
460001	21.7996	22.2735	23.5485	22.5533
460003	20.0452	22.6289	22.9549	21.8157
460004	21.3744	21.7234	23.1289	22.0969
460005	19.7069	22.5252	23.0189	21.6769
460006	20.6252	21.0700	22.1648	21.3374
460007	20.8026	21.1922	22.0409	21.4007
460008	18.8661	19.1153	22.6808	20.2069
460009	21.9016	22.5295	23.1933	22.5366
460010	21.9830	22.4948	24.0907	22.8868
460011	18.8660	19.7674	25.3818	20.9922
460013	20.7326	20.1936	21.2360	20.7330
460014	18.3865	18.5370	*	18.4531
460015	20.6593	21.0470	22.4872	21.4209
460016	18.2408	21.9105	19.0910	19.6368
460017	17.7103	18.9929	19.0724	18.5937
460018	17.6235	17.0063	17.0385	17.1969
460019	16.2671	17.8690	19.3442	17.7589
460020	17.3467	17.2663	18.1542	17.5580
460021	21.0470	21.5174	23.1368	21.9697
460022	20.1534	21.3614	20.7539	20.7266
460023	22.3535	22.9265	24.1825	23.1937
460025	19.4247	17.3494	17.4070	17.9267
460026	19.9241	20.2576	21.1759	20.4671
460027	21.8868	22.2955	21.4833	21.8607

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
460029	20.5154	20.8366	23.7148	21.6548
460030	17.6071	17.1383	18.7655	17.8282
460032	21.1006	21.4832	21.0286	21.1954
460033	19.5372	19.2664	20.2389	19.6949
460035	16.0021	16.1685	15.6979	15.9450
460036	23.5893	23.4573	24.2651	23.7927
460037	18.6850	17.7399	19.0115	18.4898
460039	24.9134	24.4808	24.5134	24.6186
460041	21.0623	20.2035	21.6676	20.9770
460042	18.8814	19.5662	19.7531	19.4200
460043	24.4779	23.2819	25.1366	24.2896
460044	21.4696	21.8485	23.6604	22.3504
460046	18.2224	*	*	18.2224
460047	23.0433	22.7524	23.5447	23.1136
460049	19.6483	20.8283	21.5241	20.8906
460051	19.4761	22.1758	21.8950	21.1889
460052	*	19.8961	20.1989	20.0325
470001	20.2299	21.3817	21.7774	21.1523
470003	23.6949	22.0563	23.3612	23.0272
470004	16.8842	18.1879	17.3576	17.4706
470005	21.9191	23.1808	22.6589	22.5826
470006	17.8699	20.2829	21.0835	19.7003
470008	19.6069	20.1969	20.3833	20.0728
470010	20.2961	21.0616	22.3913	21.2927
470011	21.7675	22.2415	24.1306	22.7075
470012	18.5339	18.9444	19.8831	19.1162
470015	19.5366	20.2125	21.8204	20.4728
470018	21.5426	21.2406	24.8493	22.4355
470020	20.6643	21.5688	21.9911	21.4308
470023	20.4511	21.7139	22.5334	21.5811
470024	20.8510	21.9807	23.2738	22.0567
490001	21.9755	20.0570	21.4952	21.1603
490002	15.2287	15.7365	16.5198	15.8281
490003	19.1040	20.3237	20.7688	20.0621
490004	19.2126	19.7074	20.7616	19.8936
490005	20.5517	21.3318	23.1708	21.7445
490006	15.9537	12.3253	19.8977	16.1242
490007	18.7740	19.8938	20.7896	19.8261
490009	23.9344	23.7659	24.7602	24.1271
490010	21.7424	*	*	21.7424
490011	18.6071	19.8042	19.8179	19.3919
490012	15.9973	15.2965	16.0994	15.7867
490013	17.3318	18.2396	18.3901	17.9911
490014	25.8315	23.5266	27.8907	25.6619
490015	19.6363	20.0667	21.4500	20.3969
490017	18.4361	19.3854	19.6594	19.1681
490018	18.3435	18.5508	19.8955	18.9343
490019	19.6178	21.0124	21.6790	20.8153
490020	18.5691	19.3424	20.9212	19.6001
490021	19.3945	20.0496	21.2263	20.2509
490022	21.2183	22.3380	24.3008	22.6504
490023	20.6694	21.5683	22.8400	21.7338
490024	17.7221	18.4314	19.7491	18.7525
490027	16.2761	16.7556	17.5178	16.8693
490030	9.1789	8.6446	*	8.9749
490031	14.9539	16.0003	17.4262	16.1268
490032	22.4262	21.4037	22.2041	22.0055
490033	21.1723	19.2908	23.2088	21.1528
490037	16.3759	17.0113	17.2117	16.8638
490038	21.0218	17.6324	18.6012	18.9881
490040	22.7061	24.1266	25.5461	24.1416
490041	18.3589	18.7987	17.9942	18.3695
490042	16.4666	17.0972	18.1864	17.2848
490043	22.1574	22.1068	23.5367	22.5696
490044	18.3137	19.7842	18.4845	18.8757
490045	20.5468	20.5558	22.5238	21.2366

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
490046	18.4825	19.9102	19.8518	19.4329
490047	25.0438	18.7614	20.1660	20.7033
490048	18.4361	19.5417	20.9110	19.5970
490050	23.0729	23.3668	23.8519	23.4357
490052	16.8600	16.4787	18.5693	17.2849
490053	15.6996	16.8410	17.7363	16.7991
490054	15.4734	19.5780	22.5136	19.1813
490057	19.9210	20.3160	21.1871	20.4871
490059	20.8662	21.4801	24.1516	22.0719
490060	17.6308	18.5917	19.3525	18.5249
490063	28.6536	26.1930	28.0906	27.6046
490066	20.6972	19.8352	21.5920	20.7067
490067	17.0195	17.8487	18.6469	17.8519
490069	17.3297	20.7582	18.8335	18.9275
490071	21.8879	23.3511	24.1882	23.1205
490073	20.7960	26.0957	*	23.1759
490075	18.6983	19.2156	20.5801	19.4875
490077	21.3670	22.6504	21.9175	21.9708
490079	17.0815	17.7016	17.5839	17.4571
490084	16.7834	18.0555	18.9679	17.9259
490085	17.4584	17.6158	19.4261	18.1708
490088	16.4362	17.9141	19.1924	17.7544
490089	17.7692	18.2290	19.7936	18.6306
490090	17.0199	17.5799	19.2094	17.9357
490091	20.8734	25.0272	23.7493	22.9790
490092	16.9533	16.4360	27.1805	18.9439
490093	17.3711	17.8275	19.1131	18.1170
490094	18.9204	22.3033	20.2020	20.4445
490097	15.5780	16.9518	16.6563	16.3410
490098	15.1403	16.0488	18.5133	16.5089
490099	17.9665	18.3985	19.2604	18.5294
490100	22.5010	*	*	22.5010
490101	24.7616	23.5553	25.7804	24.7017
490104	25.6889	40.2529	17.1683	24.3080
490105	18.5765	21.4428	28.7831	21.5414
490106	17.6596	26.3821	31.8566	22.3213
490107	23.5240	22.9283	23.9962	23.5071
490108	20.2112	24.1232	24.8596	22.6562
490109	23.6620	25.9475	23.0609	24.1978
490110	16.5131	18.1561	18.8042	17.8380
490111	17.1768	17.8510	19.9552	18.3170
490112	21.4532	22.1162	23.2843	22.3013
490113	23.2235	23.9043	26.1840	24.4577
490114	17.3047	18.0359	18.8920	18.0825
490115	16.5203	16.8537	18.4499	17.2731
490116	16.6170	17.2040	18.2935	17.3997
490117	14.0104	14.7944	17.1723	15.3528
490118	21.4674	23.2022	24.2668	22.9444
490119	17.9147	18.6046	18.9535	18.4822
490120	19.3707	20.5777	20.6828	20.2247
490122	23.8801	23.8198	26.6681	24.7636
490123	17.7461	19.3056	20.0920	19.0902
490124	22.0884	21.3818	23.6526	22.4301
490126	18.6844	20.4294	19.0782	19.3248
490127	16.0516	16.5993	17.6437	16.7293
490129	22.5885	28.6868	*	23.5799
490130	16.4322	17.6943	18.6406	17.5834
490132	18.6570	18.4671	19.1742	18.7508
500001	22.1896	24.4829	25.3478	23.9717
500002	21.6332	19.8476	22.9942	21.4749
500003	24.2814	24.4333	25.1200	24.6216
500005	22.3955	24.3870	26.2066	24.2052
500007	26.0599	21.9911	24.7889	24.1708
500008	25.3064	26.1737	27.2852	26.2556
500011	24.0162	24.6554	25.7263	24.7924
500012	20.7032	24.2799	24.5450	23.0771

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
500014	24.3419	24.0990	25.0490	24.4936
500015	23.9297	24.9923	25.9465	24.9911
500016	24.3938	24.9439	25.1227	24.8306
500019	22.4213	23.2054	23.5730	23.0604
500021	25.9198	27.6490	25.9403	26.4613
500023	26.6535	27.1025	32.3079	28.0325
500024	23.7472	26.6452	26.2113	25.5094
500025	26.4810	24.4825	27.3697	26.1011
500026	23.8005	26.9884	26.6108	25.7916
500027	22.2158	25.1125	27.7429	25.0474
500028	19.2675	18.9556	19.0261	19.0887
500029	17.9237	18.5042	19.3130	18.5707
500030	24.9039	26.3828	28.5297	26.6182
500031	29.2707	23.6099	25.8542	26.0586
500033	22.3527	22.5462	23.8994	22.9522
500036	22.1096	23.6333	25.1255	23.5838
500037	20.7139	21.4059	22.1774	21.4194
500039	23.8918	24.0007	25.4225	24.4379
500041	23.9608	25.4376	24.7070	24.7067
500042	22.9125	*	*	22.9125
500043	20.9459	22.0466	24.1745	22.4162
500044	23.3364	24.2212	24.7816	24.1154
500045	20.8881	24.0526	24.6265	23.0766
500048	22.1906	20.3207	20.6333	21.0462
500049	24.0489	24.5997	26.5857	25.0314
500050	22.0065	22.6563	23.0804	22.6053
500051	24.8203	25.9447	26.7628	25.8820
500053	23.9397	22.8399	24.2492	23.6675
500054	22.8829	23.8089	25.7815	24.1708
500055	23.7446	23.8622	23.7988	23.8022
500057	18.2737	19.0479	20.5812	19.3310
500058	24.7882	24.1106	26.5679	25.1920
500059	23.3506	26.6270	25.3528	25.0566
500060	25.0233	28.3655	29.6030	27.5162
500061	21.7013	20.8624	24.5908	22.4271
500062	18.6329	19.0557	19.1685	18.9583
500064	25.5748	26.7000	27.5791	26.6387
500065	21.9308	23.5671	24.0966	23.2140
500068	19.6574	19.2638	20.9278	19.9560
500069	21.3592	21.4542	22.4158	21.7566
500071	19.1906	19.1428	22.3253	20.1059
500072	25.3928	25.2001	25.7734	25.4637
500073	21.2469	21.7698	22.5222	21.8777
500074	18.9679	19.5981	20.6120	19.7482
500077	22.8536	23.9410	24.5695	23.7818
500079	24.2036	23.1041	24.7946	24.0303
500080	15.6630	18.3883	18.8188	17.4053
500084	23.4032	24.4044	25.0556	24.3257
500085	21.4403	20.4517	20.7422	20.8523
500086	23.3288	22.8829	24.2556	23.4907
500088	23.2701	25.2478	26.4212	24.8779
500089	18.7080	19.7166	20.3478	19.5281
500090	16.1576	20.4429	21.7716	18.7859
500092	16.7913	19.2028	20.3058	18.6898
500094	18.5835	15.7866	17.6625	17.4874
500096	21.0151	23.3564	25.1135	23.2107
500097	19.7706	20.8774	21.4423	20.6699
500098	16.3511	15.2040	17.8453	16.4653
500101	19.7337	15.8000	19.8614	18.4197
500102	20.9389	21.8963	23.1307	22.0050
500104	22.8154	24.9389	24.7875	24.1421
500106	18.6041	19.1465	17.1066	18.3020
500107	18.1201	17.9489	17.4641	17.8401
500108	26.2939	28.6229	26.1609	27.0259
500110	21.4553	22.9775	23.5941	22.6736
500118	23.8397	24.8034	24.7875	24.4924

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
500119	22.4373	22.1192	23.9939	22.8469
500122	22.4268	23.5264	24.4462	23.5112
500123	20.3181	19.6646	21.7133	20.7526
500124	23.2836	23.7742	24.6591	23.9700
500125	15.1112	14.7910	15.6304	15.1911
500129	26.1575	25.4685	25.2082	25.5438
500132	15.6717	23.1822	21.9915	20.2081
500134	17.7457	17.2430	15.9791	16.9729
500139	22.2297	22.3053	23.7993	22.7606
500141	23.8838	29.9695	28.1014	27.3199
500143	18.0343	18.2570	18.7523	18.3736
500146	21.6003	*	*	21.6002
510001	19.1492	20.0429	20.2514	19.8050
510002	20.1527	17.6392	19.1517	18.9313
510005	14.2503	13.8621	13.8641	13.9934
510006	18.7313	19.9609	19.9760	19.5653
510007	21.2729	21.6761	22.9326	21.9765
510008	18.3296	19.0513	19.9176	19.1112
510012	15.8390	15.6089	15.8596	15.7743
510013	17.8527	19.5798	18.3486	18.5734
510015	14.9039	16.7311	17.1595	16.3249
510018	18.5269	18.5358	18.3023	18.4548
510020	13.1837	14.1211	15.7512	14.3266
510022	20.1763	21.5770	21.4336	21.0418
510023	16.0129	16.7777	17.6516	16.8122
510024	19.0941	18.7461	19.6521	19.1601
510026	13.6888	13.7952	14.8785	14.0865
510027	17.2900	18.5945	20.5222	18.7968
510028	20.0628	19.9208	22.4826	20.8230
510029	17.7124	18.4668	18.9000	18.3777
510030	17.4198	17.7603	19.2558	18.1712
510031	28.6673	18.6341	19.3049	21.2106
510033	18.4082	18.4718	19.6900	18.8637
510035	16.5007	18.3164	21.8290	18.6848
510036	13.4559	13.8786	15.0266	14.0903
510038	15.8132	15.5576	15.9821	15.7873
510039	16.9398	17.1461	17.4002	17.1582
510043	14.0662	13.1308	14.4202	13.8751
510046	17.3821	18.5896	18.7424	18.2568
510047	19.8963	20.8101	21.2885	20.6282
510048	21.0407	17.1647	15.2886	17.8240
510050	16.9136	18.4036	18.3964	17.9380
510053	16.1036	17.5798	18.1046	17.2603
510055	23.7248	24.2133	25.6333	24.5104
510058	18.4156	18.4501	18.6025	18.4938
510059	16.5854	16.1044	17.3844	16.6208
510060	17.5594	*	*	17.5594
510061	13.8204	14.1968	14.6774	14.2360
510062	19.3881	18.1588	19.7202	19.0675
510066	12.2943	*	*	12.2943
510067	16.7161	17.3067	17.8816	17.3091
510068	18.7938	23.0452	19.4299	20.2577
510070	18.5146	18.7091	18.6226	18.6195
510071	17.2148	18.0278	18.8766	18.0317
510072	15.6262	15.9257	16.5279	16.0216
510077	18.0668	18.2947	20.4521	18.9028
510080	17.4485	16.3453	19.7131	17.6898
510081	13.6359	11.9701	10.4972	11.9879
510082	17.4538	13.5946	16.0014	15.5120
510084	17.2395	13.5339	14.9683	15.2567
510085	17.5624	18.6227	19.0175	18.4360
510086	13.4763	14.2241	16.3413	14.6710
510088	*	14.8854	16.2850	15.6272
520002	19.7447	19.6755	20.2691	19.9110
520003	17.1248	18.7956	18.7507	18.2896
520004	19.6512	20.4591	21.1549	20.3927

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
520006	21.5313	21.4884	22.4099	21.7879
520007	16.2001	18.4629	18.3959	17.6275
520008	22.8024	24.9395	24.4927	24.0917
520009	18.6002	21.4638	19.8142	19.9388
520010	22.7703	22.3311	25.5623	23.5734
520011	20.7410	21.5223	21.6945	21.3155
520013	20.3965	20.5944	22.1009	21.0588
520014	17.1646	18.0841	19.2760	18.1480
520015	18.6078	19.7672	21.0428	19.8323
520016	17.3018	18.4320	19.5656	18.4077
520017	19.6008	19.4780	21.1409	20.0934
520018	21.1941	21.5279	22.1929	21.6736
520019	19.5440	20.9164	21.8870	20.7980
520021	21.3471	21.9531	22.8484	22.1016
520024	14.0175	14.4750	16.4879	15.0572
520025	18.2430	20.3838	21.9529	20.1629
520026	21.5453	20.8546	22.4779	21.6324
520027	19.9324	21.5868	22.1450	21.2250
520028	21.2852	22.5941	22.0333	21.9368
520029	19.5750	21.4197	21.5561	20.8404
520030	20.5039	21.6311	22.7239	21.6241
520031	20.4814	20.9875	21.2809	20.8937
520032	19.5697	21.1069	24.1092	21.5816
520033	19.2954	20.2520	21.0088	20.1750
520034	17.1282	20.4307	21.5275	19.7188
520035	18.9452	18.7135	19.8917	19.2020
520037	20.6686	21.6017	23.0801	21.8015
520038	19.6294	20.6130	21.4208	20.5296
520039	20.7641	23.3687	21.1719	21.6634
520040	20.4677	21.2023	23.0710	21.5679
520041	17.1959	18.4117	18.2997	17.9850
520042	18.5843	19.5466	20.6354	19.6057
520044	18.4014	19.1877	21.4913	19.6621
520045	20.5917	21.2427	21.9812	21.2870
520047	18.3048	20.3487	21.0370	19.8304
520048	20.6583	19.8926	20.3488	20.2938
520049	20.3559	20.1667	21.8271	20.7868
520051	21.6497	24.0460	23.4366	23.0036
520053	17.3945	18.0851	18.9512	18.1443
520054	15.1747	16.8363	16.6278	16.1750
520057	19.0872	19.8492	20.6959	19.9036
520058	19.7283	21.2500	23.6794	21.5351
520059	20.9913	21.5796	22.1618	21.5868
520060	17.9258	18.8232	20.3357	19.0291
520062	19.1482	19.7038	21.2865	20.0649
520063	19.6136	20.5262	21.2774	20.4843
520064	22.7423	22.0917	23.8181	22.8706
520066	22.8837	24.0087	25.4528	24.0196
520068	18.9943	19.6855	20.6112	19.7565
520069	20.2934	20.1770	21.7233	20.5221
520070	18.5938	19.4261	20.0096	19.3562
520071	18.7304	19.9866	22.0066	20.1801
520074	20.4601	20.9007	21.6636	20.9770
520075	19.8457	20.7301	22.1894	20.9388
520076	17.6088	19.5878	20.6155	19.2421
520077	17.7830	18.7119	18.1077	18.2004
520078	21.3380	21.7545	21.7414	21.6174
520082	17.7405	*	*	17.7405
520083	23.8849	23.5787	24.2401	23.9015
520084	20.8427	23.5446	21.8102	22.0208
520087	20.3624	20.7821	22.2579	21.1364
520088	20.6312	21.8931	22.3921	21.5920
520089	21.5456	22.1055	23.2335	22.2891
520090	18.9343	20.3645	20.9069	20.0854
520091	20.9927	20.9440	22.2218	21.3884
520092	17.6500	18.6248	19.7181	18.6927

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
520094	20.3611	20.6179	21.3082	20.7652
520095	20.3269	18.6425	21.9177	20.2122
520096	19.7757	20.6668	21.6803	20.7358
520097	20.2354	20.8016	22.2375	21.1096
520098	22.3348	23.4707	25.0055	23.6219
520100	18.3832	19.4788	20.5366	19.4712
520101	19.5186	19.9875	20.0164	19.8451
520102	20.1898	21.0138	22.3640	21.1849
520103	19.4809	20.1092	22.2765	20.6137
520107	20.3747	21.7907	23.8421	21.9354
520109	19.1303	19.7609	20.3208	19.7432
520110	20.4494	21.0055	22.3923	21.3276
520111	17.7834	17.7673	18.2744	17.9282
520112	19.1797	18.9577	17.6226	18.3876
520113	21.1485	21.8852	23.1852	22.0983
520114	16.6616	17.8476	18.5767	17.6415
520115	18.2980	19.2248	21.4279	19.6231
520116	19.8509	20.6922	22.2741	20.9026
520117	18.5414	18.3963	19.3653	18.7838
520118	14.2326	14.8626	13.9920	14.3519
520120	18.7437	*	*	18.7436
520121	19.7305	20.8492	20.9422	20.5799
520122	16.2436	16.9335	16.9905	16.7143
520123	17.3980	17.7986	19.8134	18.4575
520124	17.2619	17.9205	19.2621	18.1369
520130	15.6845	16.6873	18.8845	17.0161
520131	18.7295	20.2591	21.0400	20.0321
520132	15.6379	18.1630	18.2634	17.2681
520134	18.0953	18.8150	19.6881	18.8725
520135	15.8246	17.3476	18.1026	17.0799
520136	19.8480	20.9050	21.3966	20.7380
520138	21.2260	22.5599	23.1498	22.3142
520139	20.9988	21.4042	22.8070	21.7325
520140	21.5207	22.3671	22.5459	22.1346
520142	20.5858	21.9432	21.4120	21.2420
520144	18.5701	19.9120	20.5864	19.6719
520145	18.2654	18.7958	20.3461	19.0923
520146	17.9585	18.2370	18.6337	18.2882
520148	17.2421	19.1502	20.5075	19.0048
520149	14.1901	12.8928	13.8614	13.6192
520151	17.3267	18.7070	19.3362	18.4627
520152	19.5858	22.5980	26.2402	22.5080
520153	15.9753	17.0863	18.5986	17.1925
520154	18.5403	19.5994	21.0486	19.7479
520156	21.3377	20.9638	20.7808	21.0122
520157	17.1974	19.6008	21.6821	19.4299
520159	18.6760	17.7649	21.8783	19.4305
520160	19.4173	20.5154	21.5871	20.5304
520161	19.4905	20.1102	21.4038	20.3456
520170	21.5233	21.9857	23.0867	22.2181
520171	17.4560	18.0785	18.1844	17.8993
520173	21.3016	20.9209	23.2955	21.8315
520177	22.7221	24.0139	25.0908	23.8719
520178	18.6936	20.9010	23.1509	20.7167
520188	13.9135	*	*	13.9135
520189	*	*	22.0889	22.0889
530002	19.3273	21.0560	23.0582	21.0877
530003	16.2139	15.9523	17.1646	16.4518
530004	15.0497	13.3788	17.4672	15.2335
530005	13.3529	15.3255	18.4391	15.7635
530006	18.5894	19.1305	20.7661	19.4956
530007	18.5161	17.7897	18.5286	18.3005
530008	18.8349	19.0113	19.5386	19.1231
530009	22.5009	21.7795	23.5839	22.6178
530010	21.6092	13.9536	17.8687	17.3468
530011	18.7354	19.4606	19.9212	19.3808

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2001 (1997 WAGE DATA), 2002 (1998 WAGE DATA), AND 2003 (1999 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

[Explanation of footnotes: * Denotes wage data not available for the provider for that year. ** Based on the sum of the salaries and hours computed for Federal FYs 2001, 2002, and 2003.]

Provider No.	Average hourly wage FY 2001	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly ** wage (3 yrs)
530012	18.9923	21.1854	22.5084	20.9252
530014	18.0869	18.4900	20.0422	18.9065
530015	22.4568	23.4040	24.6527	23.4897
530016	18.1562	19.3205	20.3647	19.2610
530017	16.3478	17.7736	20.9408	18.2556
530018	18.3783	19.5986	20.1226	19.3605
530019	18.5430	20.1097	18.1492	18.8643
530022	18.5002	19.6136	19.7902	19.3159
530023	20.1948	20.0677	21.6352	20.6416
530025	21.2598	22.0300	22.4816	21.9309
530026	17.0118	19.8969	20.9919	19.1178
530027	18.1664	25.5067	*	20.8124
530029	16.5092	19.3361	20.3046	18.6145
530031	18.3322	20.1734	23.2766	20.4477
530032	21.0361	20.0132	20.9856	20.6817

TABLE 3A.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS

[*Based on the sum of the salaries and hours computed for FYs 2001, 2002, and 2003]

Urban area	FY 2003 average hourly wage	3-Year average hourly wage
Abilene, TX	18.0997	17.9346
Aguadilla, PR	10.6548	10.3692
Akron, OH	22.2995	21.8274
Albany, GA	24.6091	23.3345
Albany-Schenectady-Troy, NY	19.4753	19.0093
Albuquerque, NM	21.6385	21.0779
Alexandria, LA	18.2564	17.9570
Allentown-Bethlehem-Easton, PA	22.6149	22.2151
Altoona, PA	21.4284	20.7196
Amarillo, TX	20.9866	19.8100
Anchorage, AK	28.7078	28.2120
Ann Arbor, MI	25.7925	25.0051
Anniston, AL	18.6862	18.3987
Appleton-Oshkosh-Neenah, WI	20.9007	20.4194
Arecibo, PR	10.0744	10.0865
Asheville, NC	22.9425	21.4360
Athens, GA	23.7189	22.3278
Atlanta, GA	23.2091	22.5586
Atlantic-Cape May, NJ	25.5908	25.0328
Auburn-Opelika, AL	19.3393	18.4481
Augusta-Aiken, GA-SC	23.8429	21.9436
Austin-San Marcos, TX	22.3866	21.5758
Bakersfield, CA	22.9941	21.7697
Baltimore, MD	23.0654	21.7957
Bangor, ME	22.4487	21.5421

TABLE 3A.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the salaries and hours computed for FYs 2001, 2002, and 2003]

Urban area	FY 2003 average hourly wage	3-Year average hourly wage
Barnstable-Yarmouth, MA	30.6686	30.4086
Baton Rouge, LA	19.2668	18.9000
Beaumont-Port Arthur, TX	19.3363	19.0595
Bellingham, WA	28.5297	26.6182
Benton Harbor, MI	21.0032	19.8689
Bergen-Passaic, NJ	28.2237	26.6914
Billings, MT	20.9586	20.9004
Biloxi-Gulfport-Pascagoula, MS	20.3430	19.0627
Binghamton, NY	19.3760	19.0441
Birmingham, AL	21.4215	19.7657
Bismarck, ND	18.5193	17.6555
Bloomington,IN	20.6895	19.8190
Bloomington-Normal, IL	21.1609	20.3703
Boise City, ID	21.6276	20.5028
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	26.0991	25.2557
Boulder-Longmont, CO	22.5070	21.8737
Brazoria, TX	19.8267	19.0174
Bremerton, WA	25.4225	24.4379
Brownsville-Harlingen-San Benito, TX	20.6287	19.9271
Bryan-College Station, TX	20.4911	19.6440
Buffalo-Niagara Falls, NY	21.7541	21.2343
Burlington, VT	23.3505	22.9143

TABLE 3A.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the salaries and hours computed for FYs 2001, 2002, and 2003]

Urban area	FY 2003 average hourly wage	3-Year average hourly wage
Caguas, PR	10.1529	10.1915
Canton-Massillon, OH	20.7477	19.7875
Casper, WY	22.5084	20.9252
Cedar Rapids, IA	21.0377	19.8268
Champaign-Urbana, IL	24.7040	21.7883
Charleston-North Charleston, SC	21.4522	20.5545
Charleston, WV	20.6688	20.4836
Charlotte-Gastonia-Rock Hill, NC-SC	22.8817	21.3842
Charlottesville, VA	24.2460	23.7478
Chattanooga, TN-GA	20.8502	21.0493
Cheyenne, WY	20.0422	18.9065
Chicago, IL	25.6542	24.8517
Chico-Paradise, CA	22.6375	22.0699
Cincinnati, OH-KY-IN	21.7907	21.1359
Clarksville-Hopkinsville, TN-KY	19.5257	18.6578
Cleveland-Lorain-Elyria, OH	22.4627	21.4566
Colorado Springs, CO	23.0332	21.9728
Columbia, MO	19.7346	19.5385
Columbia, SC	21.6187	21.2189
Columbus, GA-AL	19.4516	18.9827
Columbus, OH	22.6508	21.6208
Corpus Christi, TX	20.2762	19.3824
Corvallis, OR	26.6038	25.7705
Cumberland, MD-WV	18.2292	18.3160
Dallas, TX	23.2252	22.3304
Danville, VA	20.5801	19.4875

TABLE 3A.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the salaries and hours computed for FYs 2001, 2002, and 2003]

Urban area	FY 2003 average hourly wage	3-Year average hourly wage
Davenport-Moline-Rock Island, IA-IL	20.5222	19.7346
Dayton-Springfield, OH	21.5613	20.8864
Daytona Beach, FL	21.0510	20.3725
Decatur, AL	20.8446	19.7238
Decatur, IL	18.7105	18.0859
Denver, CO	24.6248	23.2619
Des Moines, IA	20.4201	19.9495
Detroit, MI	24.2703	23.5057
Dothan, AL	18.9020	17.9750
Dover, DE	21.7344	22.1849
Dubuque, IA	20.4304	19.4823
Duluth-Superior, MN-WI	24.0835	22.9655
Dutchess County, NY	24.8186	23.5537
Eau Claire, WI	20.7949	19.9455
El Paso, TX	21.5232	20.8151
Elkhart-Goshen, IN	22.5833	21.3571
Elmira, NY	19.5496	18.9705
Enid, OK	19.4579	18.9430
Erie, PA	20.7316	19.9094
Eugene-Springfield, OR	25.4233	24.9294
Evansville, Henderson, IN-KY	18.9947	18.5939
Fargo-Moorhead, ND-MN	22.4962	20.6192
Fayetteville, NC	20.6496	19.8938
Fayetteville-Springdale-Rogers, AR	18.8149	18.2982
Flagstaff, AZ-UT	24.8141	23.9367
Flint, MI	25.8662	24.8502
Florence, AL	18.1004	17.3804
Florence, SC	20.3953	19.6524
Fort Collins-Loveland, CO	23.3824	22.9964
Fort Lauderdale, FL	23.9183	22.9781
Fort Myers-Cape Coral, FL	22.4867	21.1683
Fort Pierce-Port St. Lucie, FL	22.8186	22.1142
Fort Smith, AR-OK	18.3399	17.9436
Fort Walton Beach, FL	22.5165	21.1838
Fort Wayne, IN	21.9677	20.4543
Fort Worth-Arlington, TX	21.9417	21.2344
Fresno, CA	23.7314	22.6694
Gadsden, AL	19.7567	19.2100
Gainesville, FL	22.9298	21.9827
Galveston-Texas City, TX	21.9867	22.1243
Gary, IN	22.2630	21.3794
Glens Falls, NY	19.2366	18.6783
Goldsboro, NC	20.6547	19.5049
Grand Forks, ND-MN	20.6675	19.9946
Grand Junction, CO	21.9661	21.0658
Grand Rapids-Muskegon-Holland, MI	22.1261	22.2833
Great Falls, MT	20.7913	20.0975
Greeley, CO	21.4562	21.3343
Green Bay, WI	22.0738	20.9151
Greensboro-Winston-Salem-High Point, NC	21.5609	20.8887
Greenville, NC	21.1397	20.7708
Greenville-Spartanburg-Anderson, SC	21.1902	20.4530
Hagerstown, MD	21.5280	20.1745
Hamilton-Middletown, OH	21.8770	20.8017
Harrisburg-Lebanon-Carlisle, PA	21.4246	21.2205
Hartford, CT	26.8283	25.7523
Hattiesburg, MS	17.7923	16.9367
Hickory-Morganton-Lenoir, NC	20.9718	20.4830
Honolulu, HI	26.6135	26.0576
Houma, LA	19.4770	18.2833
Houston, TX	22.9793	21.8906
Huntington-Ashland, WV-KY-OH	22.3832	21.7861
Huntsville, AL	20.6802	19.9807
Indianapolis, IN	22.5719	21.8463
Iowa City, IA	22.2708	21.7514
Jackson, MI	22.1433	20.9286
Jackson, MS	19.9947	19.3644
Jackson, TN	21.5461	20.3227
Jacksonville, FL	21.7926	20.8047
Jacksonville, NC	19.1386	17.6977
Jamestown, NY	18.5274	17.7979
Janesville-Beloit, WI	22.8793	21.7876
Jersey City, NJ	25.9930	25.3096
Johnson City-Kingsport-Bristol, TN-VA	19.2068	18.8084
Johnstown, PA	19.3478	19.3566
Jonesboro, AR	18.0006	17.9165
Joplin, MO	20.0072	19.0679
Kalamazoo-Battlecreek, MI	24.6108	23.6975
Kankakee, IL	18.8681	20.7325
Kansas City, KS-MO	22.6159	21.5239
Kenosha, WI	22.4996	21.6484
Killeen-Temple, TX	22.2296	21.1752
Knoxville, TN	20.8376	19.6060
Kokomo, IN	20.8390	20.6388
La Crosse, WI-MN	21.8354	20.8331
Lafayette, LA	19.6879	19.0782
Lafayette, IN	21.5534	20.3600
Lake Charles, LA	18.5034	17.2671
Lakeland-Winter Haven, FL	21.7369	20.7023
Lancaster, PA	21.0878	20.6617
Lansing-East Lansing, MI	22.5939	21.9285
Laredo, TX	19.6806	18.3545
Las Cruces, NM	20.3141	19.4697
Las Vegas, NV-AZ	26.7621	25.1310
[1] Lawrence, KS	.....	17.8290
Lawton, OK	19.3161	19.4211
Lewiston-Auburn, ME	21.3222	20.5843
Lexington, KY	19.9333	19.6141
Lima, OH	22.0292	21.1697
Lincoln, NE	22.9794	22.2323
Little Rock-North Little Rock, AR	21.1311	20.1533
Longview-Marshall, TX	20.0437	19.5274
Los Angeles-Long Beach, CA	27.8780	26.8744
Louisville, KY-IN	21.5487	21.0505
Lubbock, TX	22.4063	20.0797
Lynchburg, VA	21.4142	20.3464
Macon, GA	21.3800	20.3043
Madison, WI	24.3133	23.2497
Mansfield, OH	20.6732	19.6809
Mayaguez, PR	11.4145	10.7192
McAllen-Edinburg-Mission, TX	19.5785	18.9844
Medford-Ashland, OR	24.3865	23.3354
Melbourne-Titusville-Palm Bay, FL	23.8179	22.3779
Memphis, TN-AR-MS	20.7202	19.9037
Merced, CA	22.8511	21.9541
Miami, FL	22.7695	22.2828
Middlesex-Somerset-Hunterdon, NJ	26.0484	25.2231
Milwaukee-Waukesha, WI	22.9802	22.1540
Minneapolis-St. Paul, MN-WI	25.3271	24.5840
Missoula, MT	21.2713	20.8023
Mobile, AL	18.8354	18.2108
Modesto, CA	24.3874	23.6713
Monmouth-Ocean, NJ	24.7950	24.5325
Monroe, LA	18.9030	18.4972
Montgomery, AL	17.9647	17.0004
Muncie, IN	21.5664	22.4947
Myrtle Beach, SC	20.8503	19.6435
Naples, FL	22.6587	21.7978
Nashville, TN	22.2485	21.5537
Nassau-Suffolk, NY	31.0283	30.5926
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	28.8227	27.6131
New London-Norwich, CT	27.3351	26.4541
New Orleans, LA	21.0139	20.4714
New York, NY	33.4837	32.5033
Newark, NJ	26.4381	26.0353
Newburgh, NY-PA	26.4506	24.9836
Norfolk-Virginia Beach-Newport News, VA-NC	19.9175	19.1247
Oakland, CA	35.0108	33.9487
Ocala, FL	21.8400	21.1289
Odessa-Midland, TX	21.8283	21.4760
Oklahoma City, OK	20.6736	19.7312
Olympia, WA	25.4588	24.6677
Omaha, NE-IA	23.1783	21.8976
Orange County, CA	26.6537	25.4571
Orlando, FL	22.3924	21.6364
Owensboro, KY	19.3837	18.5916
Panama City, FL	20.5934	20.1588
Parkersburg-Marietta, WV-OH	18.8778	18.3560
Pensacola, FL	20.0814	18.8080
Peoria-Pekin, IL	20.2998	19.5517
Philadelphia, PA-NJ	24.8854	24.3569
Phoenix-Mesa, AZ	22.8121	21.8188

TABLE 3A.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the salaries and hours computed for FYs 2001, 2002, and 2003]

Urban area	FY 2003 average hourly wage	3-Year average hourly wage
Pine Bluff, AR	18.4956	17.6590
Pittsburgh, PA	21.7554	21.4243
Pittsfield, MA	23.7753	23.0116
Pocatello, ID	21.7708	20.8557
Ponce, PR	12.0073	11.5031
Portland, ME	22.7505	21.6716
Portland-Vancouver, OR-WA	24.7790	24.4439
Providence-Warwick, RI	25.2127	24.3041
Provo-Orem, UT	23.1919	22.3508
Pueblo, CO	20.4888	19.6349
Punta Gorda, FL	21.4140	20.8215
Racine, WI	21.6818	20.8941
Raleigh-Durham-Chapel Hill, NC	23.2057	22.0194
Rapid City, SD	20.5485	19.8947
Reading, PA	21.5927	20.9553
Redding, CA	25.8663	25.3801
Reno, NV	24.7352	23.6658
Richland-Kennewick-Pasco, WA	26.6936	25.3323
Richmond-Petersburg, VA	22.0137	21.5043
Riverside-San Bernardino, CA	26.4013	25.2038
Roanoke, VA	20.0106	19.2432
Rochester, MN	28.1983	26.1811
Rochester, NY	21.3577	20.7104
Rockford, IL	22.3577	20.7042
Rocky Mount, NC	21.4359	20.3593
Sacramento, CA	26.7146	26.3841
Saginaw-Bay City-Midland, MI	22.4172	21.5444
St. Cloud, MN	22.5321	22.1278
[1] St. Joseph, MO	.....	19.7467
St. Louis, MO-IL	20.5705	20.0669
Salem, OR	24.0818	22.8500
Salinas, CA	33.9674	32.7871
Salt Lake City-Ogden, UT	23.1018	22.1636
San Angelo, TX	19.4526	18.4524
San Antonio, TX	20.3327	19.4056
San Diego, CA	25.8562	25.5485
San Francisco, CA	32.8516	31.7473
San Jose, CA	32.8581	31.3747
San Juan-Bayamon, PR	11.0133	10.6132
San Luis Obispo-Atascadero-Paso Robles, CA	26.1821	24.6268
Santa Barbara-Santa Maria-Lompoc, CA	24.3466	23.8325
Santa Cruz-Watsonville, CA	31.6979	31.1452
Santa Fe, NM	24.8842	23.5075
Santa Rosa, CA	30.3046	28.9555
Sarasota-Bradenton, FL	21.8931	21.9128
Savannah, GA	21.7802	21.7267
Scranton-Wilkes Barre-Hazleton, PA	19.9745	19.2042
Seattle-Bellevue-Everett, WA	26.6536	25.3076
Sharon, PA	18.2797	17.7479
Sheboygan, WI	20.2034	19.0865
Sherman-Denison, TX	21.4996	20.4082
Shreveport-Bossier City, LA	20.8773	20.0586
Sioux City, IA-NE	21.0135	19.6404
Sioux Falls, SD	21.5029	20.3200
South Bend, IN	22.7694	22.2819
Spokane, WA	25.2082	23.9695
Springfield, IL	20.1137	19.4530
Springfield, MO	19.5680	19.0448
Springfield, MA	25.3838	24.2450
State College, PA	20.7690	20.2726
Steubenville-Weirton, OH-WV	20.4503	19.4333
Stockton-Lodi, CA	24.4040	23.8853
Sumter, SC	19.2186	18.1995
Syracuse, NY	22.5655	21.5986
Tacoma, WA	25.4131	25.5054
Tallahassee, FL	19.7552	19.1410
Tampa-St. Petersburg-Clearwater, FL	21.0569	20.1666
Terre Haute, IN	19.9743	19.0303
Texarkana, AR-Texarkana, TX	18.7873	18.5257
Toledo, OH	22.7892	22.0065
Topeka, KS	21.3678	20.3537
Trenton, NJ	24.2326	23.1923
Tucson, AZ	20.6996	19.9488
Tulsa, OK	19.3548	19.2001
Tuscaloosa, AL	18.8861	18.2479
Tyler, TX	22.1176	21.3312
Utica-Rome, NY	19.6631	18.9748
Vallejo-Fairfield-Napa, CA	31.0202	29.7206
Ventura, CA	25.7748	24.7503
Victoria, TX	20.3401	18.8925
Vineland-Millville-Bridgeton, NJ	23.3023	23.1595
Visalia-Tulare-Portersville, CA	21.9029	21.3706
Waco, TX	18.7525	18.3223
Washington, DC-MD-VA-WV	25.2063	24.3514
Waterloo-Cedar Falls, IA	18.7434	18.3360
Wausau, WI	22.7239	21.6241
West Palm Beach-Boca Raton, FL	23.0874	21.9924
Wheeling, OH-WV	17.8161	17.4926
Wichita, KS	22.1149	21.4272
Wichita Falls, TX	19.7397	18.0189
Williamsport, PA	19.8470	19.0895
Wilmington-Newark, DE-MD	25.9552	24.8359
Wilmington, NC	22.3936	21.3149
Yakima, WA	24.5502	23.1867
Yolo, CA	21.9147	21.8929
York, PA	20.9666	20.7327
Youngstown-Warren, OH	21.7376	21.2695
Yuba City, CA	23.8705	23.4396
Yuma, AZ	19.9517	20.2223

[1] The MSA is empty for FY 2003. The hospital(s) in the MSA received rural status under Section 401 of the Balanced Budget Refinement Act of 1999 (P.L. 106-113). The MSA is assigned the statewide rural wage index (see Table 4B).

TABLE 3B.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS

[*Based on the sum of the salaries and hours computed for FYs 2001, 2002, and 2003]

Nonurban area	FY 2003 average hourly wage	3-Year average hourly wage
Alabama	17.7942	16.8216
Alaska	28.5563	27.3243
Arizona	19.7296	19.0885
Arkansas	17.8073	16.9136
California	22.8571	21.9706
Colorado	20.9408	20.0323
Connecticut	28.7895	27.0512
Delaware	21.2047	20.8163
Florida	20.4742	19.8491
Georgia	19.1171	18.5968
Hawaii	23.8213	24.2205
Idaho	20.3186	19.5606
Illinois	19.0570	18.2606
Indiana	20.3365	19.5067
Iowa	19.3165	18.3182
Kansas	18.4037	17.4835
Kentucky	18.7680	17.9289
Louisiana	17.5769	17.0854
Maine	20.6147	19.7179
Maryland	20.7803	19.8080
Massachusetts	26.2222	25.3808
Michigan	20.9071	20.1900
Minnesota	21.2579	20.2475
Mississippi	17.8404	16.9773
Missouri	18.6314	17.6923
Montana	19.7008	19.3096
Nebraska	19.0579	18.2930
Nevada	22.2480	21.3212
New Hampshire	22.7567	22.0081
New Jersey [1]	.....	.....
New Mexico	20.6102	19.5025
New York	19.8433	19.1359
North Carolina	20.1296	19.1805
North Dakota	18.0907	17.4679
Ohio	20.0074	19.4121
Oklahoma	17.6313	16.9258
Oregon	23.9324	22.8031
Pennsylvania	19.6560	19.1733
Puerto Rico	10.1187	10.0248
Rhode Island [1]	.....	.....
South Carolina	19.9939	19.0908
South Dakota	18.1545	17.3648
Tennessee	18.2990	17.6792
Texas	18.1667	17.2395
Utah	21.6314	20.5109

TABLE 3B.—FY 2003 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

[*Based on the sum of the salaries and hours computed for FYs 2001, 2002, and 2003]

Nonurban area	FY 2003 average hourly wage	3-Year average hourly wage
Vermont	21.7086	21.0072
Virginia	19.7552	18.6545
Washington	23.6461	23.0555
West Virginia	18.5259	18.1465
Wisconsin	21.2831	20.2857
Wyoming	20.9222	19.8670

[1] All counties within the State are classified as urban.

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS

Urban area (constituent counties)	Wage index	GAF
0040 [2] Abilene, TX	0.7827	0.8455
Taylor, TX		
0060 Aguadilla, PR	0.4587	0.5864
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	0.9600	0.9724
Portage, OH		
Summit, OH		
0120 Albany, GA	1.0594	1.0403
Dougherty, GA		
Lee, GA		
0160 [2] Albany-Schenectady-Troy, NY	0.8542	0.8977
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 Albuquerque, NM	0.9390	0.9578
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.7883	0.8497
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	0.9735	0.9818
Carbon, PA		
Lehigh, PA		
Northampton, PA		
0280 Altoona, PA	0.9225	0.9463
Blair, PA		
0320 Amarillo, TX Potter, TX	0.9034	0.9328
Randall, TX		
0380 Anchorage, AK	1.2490	1.1645
Anchorage, AK		
0440 Ann Arbor, MI	1.1103	1.0743
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.8044	0.8615
Calhoun, AL		
0460 [2] Appleton-Oshkosh-Neenah, WI	0.9162	0.9418

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
0470 [2] Arecibo, PR	0.4356	0.5660
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.9876	0.9915
Buncombe, NC		
Madison, NC		
0500 Athens, GA	1.0211	1.0144
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 [1] Atlanta, GA	0.9991	0.9994
Barrow, GA		
Bartow, GA		
Carroll, GA		
Cherokee, GA		
Clayton, GA		
Cobb, GA		
Coweta, GA		
DeKalb, GA		
Douglas, GA		
Fayette, GA		
Forsyth, GA		
Fulton, GA		
Gwinnett, GA		
Henry, GA		
Newton, GA		
Paulding, GA		
Pickens, GA		
Rockdale, GA		
Spalding, GA		
Walton, GA		
0560 Atlantic-Cape May, NJ	1.1017	1.0686
Atlantic, NJ		
Cape May, NJ		
0580 Auburn-Opelika, AL	0.8325	0.8820
Lee, AL		
0600 Augusta-Aiken, GA-SC	1.0264	1.0180
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 [1] Austin-San Marcos, TX	0.9637	0.9750
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 Bakersfield, CA	0.9899	0.9931
Kern, CA		
0720 [1] Baltimore, MD	0.9929	0.9951
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9664	0.9769

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.3202	1.2095
Barnstable, MA		
0760 Baton Rouge, LA	0.8294	0.8798
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8324	0.8819
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.2282	1.1511
Whatcom, WA		
0870 Benton Harbor, MI	0.9106	0.9379
Berrien, MI		
0875 [1] Bergen-Passaic, NJ	1.2207	1.1463
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.9022	0.9319
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.8757	0.9131
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 [2] Binghamton, NY	0.8542	0.8977
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.9222	0.9460
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.7972	0.8562
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.8907	0.9238
Monroe, IN		
1040 Bloomington-Normal, IL	0.9109	0.9381
McLean, IL		
1080 Boise City, ID	0.9310	0.9522
Ada, ID		
Canyon, ID		
1123 [1,2] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (MA Hospitals)	1.1288	1.0865
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals)	1.1235	1.0830
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1125 Boulder-Longmont, CO	0.9689	0.9786
Boulder, CO		
1145 Brazoria, TX	0.8535	0.8972
Brazoria, TX		
1150 Bremerton, WA	1.0944	1.0637
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.8880	0.9219
Cameron, TX		
1260 Bryan-College Station, TX	0.8821	0.9177
Brazos, TX		
1280 [1] Buffalo-Niagara Falls, NY	0.9365	0.9561
Erie, NY		
Niagara, NY		
1303 Burlington, VT	1.0052	1.0036
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4408	0.5707
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 Canton-Massillon, OH	0.8932	0.9256
Carroll, OH		
Stark, OH		
1350 Casper, WY	0.9690	0.9787
Natrona, WY		
1360 Cedar Rapids, IA	0.9056	0.9344
Linn, IA		
1400 Champaign-Urbana, IL	1.0635	1.0431
Champaign, IL		
1440 Charleston-North Charleston, SC	0.9235	0.9470
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.8898	0.9232
Kanawha, WV		
Putnam, WV		
1520 [1] Charlotte-Gastonia-Rock Hill, NC-SC	0.9850	0.9897
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Stanly, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	1.0438	1.0298
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN-GA	0.8976	0.9287
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 [2] Cheyenne, WY	0.9007	0.9309
Laramie, WY		
1600 [1] Chicago, IL	1.1044	1.0704
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 [2] Chico-Paradise, CA	0.9840	0.9890
Butte, CA		
1640 [1] Cincinnati, OH-KY-IN	0.9389	0.9577
Dearborn, IN		
Ohio, IN		
Boone, KY		
Campbell, KY		
Gallatin, KY		
Grant, KY		
Kenton, KY		
Pendleton, KY		
Brown, OH		
Clermont, OH		
Hamilton, OH		
Warren, OH		
1660 Clarksville-Hopkinsville, TN-KY	0.8419	0.8888
Christian, KY		
Montgomery, TN		
1680 [1] Cleveland-Lorain-Elyria, OH	0.9670	0.9773
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9916	0.9942
El Paso, CO		
1740 Columbia, MO	0.8515	0.8958
Boone, MO		
1760 Columbia, SC	0.9307	0.9520
Lexington, SC		
Richland, SC		
1800 Columbus, GA-AL	0.8374	0.8856
Russell, AL		
Chattahoochee, GA		
Harris, GA		
Muscogee, GA		
1840 [1] Columbus, OH	0.9751	0.9829
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8729	0.9111
Nueces, TX		
San Patricio, TX		
1890 Corvallis, OR	1.1453	1.0974
Benton, OR		
1900 [2] Cumberland, MD-WV (MD Hospitals)	0.8946	0.9266
Allegany, MD		
Mineral, WV		
1900 [2] Cumberland, MD-WV (WV Hospitals)	0.7975	0.8565
Allegany, MD		
Mineral, WV		
1920 [1] Dallas, TX	0.9998	0.9999
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.8859	0.9204
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Moline-Rock Island, IA-IL	0.8835	0.9187
Scott, IA		
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9282	0.9503
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 Daytona Beach, FL	0.9062	0.9348
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.8973	0.9285
Lawrence, AL		
Morgan, AL		
2040 [2] Decatur, IL	0.8204	0.8732
Macon, IL		
2080 [1] Denver, CO	1.0601	1.0408
Adams, CO		
Arapahoe, CO		
Broomfield, CO		
Denver, CO		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.8827	0.9181
Dallas, IA		
Polk, IA		
Warren, IA		
2160 [1] Detroit, MI	1.0448	1.0305
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.8158	0.8699
Dale, AL		
Houston, AL		
2190 Dover, DE	0.9356	0.9554
Kent, DE		
2200 Dubuque, IA	0.8795	0.9158
Dubuque, IA		
2240 Duluth-Superior, MN-WI	1.0368	1.0251
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	1.0684	1.0463
Dutchess, NY		
2290 [2] Eau Claire, WI	0.9162	0.9418
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	0.9265	0.9491
El Paso, TX		
2330 Elkhart-Goshen, IN	0.9722	0.9809
Elkhart, IN		
2335 [2] Elmira, NY	0.8542	0.8977
Chemung, NY		
2340 Enid, OK	0.8376	0.8857
Garfield, OK		
2360 Erie, PA	0.8925	0.9251
Erie, PA		
2400 Eugene-Springfield, OR	1.0944	1.0637
Lane, OR		
2440 [2] Evansville-Henderson, IN-KY (IN Hospitals)	0.8755	0.9130
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2440 Evansville-Henderson, IN-KY (KY Hospitals)	0.8177	0.8713
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND-MN	0.9684	0.9783
Clay, MN		
Cass, ND		
2560 Fayetteville, NC	0.8992	0.9298
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.8100	0.8656
Benton, AR		
Washington, AR		
2620 Flagstaff, AZ-UT	1.0682	1.0462
Coconino, AZ		
Kane, UT		
2640 Flint, MI	1.1135	1.0764
Genesee, MI		
2650 Florence, AL	0.7819	0.8449
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8780	0.9148
Florence, SC		
2670 Fort Collins-Loveland, CO	1.0066	1.0045
Larimer, CO		
2680 [1] Ft. Lauderdale, FL	1.0704	1.0477
Broward, FL		
2700 Fort Myers-Cape Coral, FL	0.9680	0.9780
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	0.9931	0.9953
Martin, FL		
St. Lucie, FL		
2720 Fort Smith, AR-OK	0.7895	0.8506
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 Fort Walton Beach, FL	0.9693	0.9789
Okaloosa, FL		
2760 Fort Wayne, IN	0.9457	0.9625
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 [1] Forth Worth-Arlington, TX	0.9446	0.9617
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.0216	1.0147
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8599	0.9018
Etowah, AL		
2900 Gainesville, FL	0.9871	0.9911
Alachua, FL		
2920 Galveston-Texas City, TX	0.9465	0.9630
Galveston, TX		
2960 Gary, IN	0.9584	0.9713
Lake, IN		
Porter, IN		
2975 [2] Glens Falls, NY	0.8542	0.8977
Warren, NY		
Washington, NY		
2980 Goldsboro, NC	0.8892	0.9227
Wayne, NC		
2985 Grand Forks, ND-MN	0.9243	0.9475
Polk, MN		
Grand Forks, ND		
2995 Grand Junction, CO	0.9679	0.9779
Mesa, CO		
3000 [1] Grand Rapids-Muskegon-Holland, MI	0.9548	0.9688
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	0.8966	0.9280
Cascade, MT		
3060 Greeley, CO	0.9336	0.9540
Weld, CO		
3080 Green Bay, WI	0.9668	0.9771
Brown, WI		
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9282	0.9503
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NCGuilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.9174	0.9427
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.9122	0.9390
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 Hagerstown, MD	0.9268	0.9493
Washington, MD		
3200 Hamilton-Middletown, OH	0.9418	0.9598
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	0.9223	0.9461
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 [1,2] Hartford, CT	1.2394	1.1583
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 [2] Hattiesburg, MS	0.7680	0.8346
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.9028	0.9324
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1457	1.0976
Honolulu, HI		
3350 Houma, LA	0.8385	0.8864

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Lafourche, LA		
Terrebonne, LA		
3360 [1] Houston, TX	0.9892	0.9926
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV-KY-OH	0.9636	0.9749
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.8903	0.9235
Limestone, AL		
Madison, AL		
3480 [1] Indianapolis, IN	0.9717	0.9805
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9587	0.9715
Johnson, IA		
3520 Jackson, MI	0.9532	0.9677
Jackson, MI		
3560 Jackson, MS	0.8607	0.9024
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.9275	0.9498
Madison, TN		
Chester, TN		
3600 [1] Jacksonville, FL	0.9381	0.9572
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 [2] Jacksonville, NC	0.8666	0.9066
Onslow, NC		
3610 [2] Jamestown, NY	0.8542	0.8977
Chautauqua, NY		
3620 Janesville-Beloit, WI	0.9849	0.9896
Rock, WI		
3640 Jersey City, NJ	1.1190	1.0800
Hudson, NJ		
3660 Johnson City-Kingsport-Bristol, TN-VA (TN Hospitals)	0.8337	0.8829
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3660 [2] Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8504	0.8950
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 [2] Johnstown, PA	0.8462	0.8919
Cambria, PA		
Somerset, PA		
3700 Jonesboro, AR	0.7843	0.8467
Craighead, AR		
3710 Joplin, MO	0.8613	0.9028
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.0595	1.0404
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 [2] Kankakee, IL	0.8204	0.8732
Kankakee, IL		
3760 [1] Kansas City, KS-MO	0.9736	0.9818
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Clinton, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
3800 Kenosha, WI	0.9686	0.9784
Kenosha, WI		
3810 Killeen-Temple, TX	0.9570	0.9704
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.8970	0.9283
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.9038	0.9331
Howard, IN		
Tipton, IN		
3870 La Crosse, WI-MN	0.9400	0.9585
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8475	0.8929
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.9278	0.9500
Clinton, IN		
Tippecanoe, IN		
3960 Lake Charles, LA	0.7965	0.8557
Calcasieu, LA		
3980 Lakeland-Winter Haven, FL	0.9357	0.9555
Polk, FL		
4000 Lancaster, PA	0.9078	0.9359
Lancaster, PA		
4040 Lansing-East Lansing, MI	0.9726	0.9812
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.8472	0.8927
Webb, TX		
4100 [2] Las Cruces, NM	0.8872	0.9213
Dona Ana, NM		
4120 [1] Las Vegas, NV-AZ	1.1521	1.1018
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.7923	0.8526
Douglas, KS		
4200 Lawton, OK	0.8315	0.8813
Comanche, OK		
4243 Lewiston-Auburn, ME	0.9179	0.9430
Androscoggin, ME		
4280 Lexington, KY	0.8581	0.9005
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.9483	0.9643
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.9892	0.9926
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.9097	0.9372
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.8629	0.9040
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 [1] Los Angeles-Long Beach, CA	1.2011	1.1337
Los Angeles, CA		
4520 [1] Louisville, KY-IN	0.9276	0.9498
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
4600 Lubbock, TX	0.9646	0.9756
Lubbock, TX		
4640 Lynchburg, VA	0.9219	0.9458
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.9250	0.9480
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	1.0467	1.0317
Dane, WI		
4800 Mansfield, OH	0.8900	0.9233
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4914	0.6147
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8428	0.8895
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0498	1.0338
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay, FL	1.0253	1.0173
Brevard, Fl		
4920 [1] Memphis, TN-AR-MS	0.8920	0.9247
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 [2] Merced, CA	0.9840	0.9890
Merced, CA		
5000 [1] Miami, FL	0.9815	0.9873
Dade, FL		
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.1213	1.0816
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 [1] Milwaukee-Waukesha, WI	0.9893	0.9927
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 [1] Minneapolis-St. Paul, MN-WI	1.0903	1.0610
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Sherburne, MN		
Washington, MN		
Wright, MN		
Pierce, WI		
St. Croix, WI		
5140 Missoula, MT	0.9157	0.9415
Missoula, MT		
5160 Mobile, AL	0.8110	0.8664
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.0498	1.0338
Stanislaus, CA		
5190 [1] Monmouth-Ocean, NJ	1.0814	1.0551
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.8137	0.8683
Ouachita, LA		
5240 Montgomery, AL	0.7734	0.8386
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 Muncie, IN	0.9284	0.9504
Delaware, IN		
5330 Myrtle Beach, SC	0.8976	0.9287
Horry, SC		
5345 Naples, FL	0.9754	0.9831
Collier, FL		
5360 [1] Nashville, TN	0.9578	0.9709
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 [1] Nassau-Suffolk, NY	1.3357	1.2192
Nassau, NY		
Suffolk, NY		
5483 [1] New Haven-Bridgeport-Stamford-Waterbury-	1.2459	1.1625
Danbury, CT		
Fairfield, CT		
New Haven, CT		
5523 [2] New London-Norwich, CT	1.2394	1.1583
New London, CT		
5560 [1] New Orleans, LA	0.9046	0.9336
Jefferson, LA		
Orleans, LA		
Plaquemines, LA		
St. Bernard, LA		
St. Charles, LA		
St. James, LA		
St. John The Baptist, LA		
St. Tammany, LA		
5600 [1] New York, NY	1.4414	1.2845
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 [1] Newark, NJ	1.1406	1.0943
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY-PA	1.1387	1.0930
Orange, NY		
Pike, PA		
5720 [1] Norfolk-Virginia Beach-Newport News, VA-NC	0.8574	0.9000
Currituck, NC		
Chesapeake City, VA		
Gloucester, VA		
Hampton City, VA		
Isle of Wight, VA		
James City, VA		
Mathews, VA		
Newport News City, VA		
Norfolk City, VA		
Poquoson City, VA		
Portsmouth City, VA		
Suffolk City, VA		
Virginia Beach City VA		
Williamsburg City, VA		
York, VA		
5775 [1] Oakland, CA	1.5185	1.3312
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.9402	0.9587
Marion, FL		
5800 Odessa-Midland, TX	0.9397	0.9583
Ector, TX		
Midland, TX		
5880 [1] Oklahoma City, OK	0.8900	0.9233
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.0960	1.0648
Thurston, WA		
5920 Omaha, NE-IA	0.9978	0.9985
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 [1] Orange County, CA	1.1594	1.1066
Orange, CA		
5960 [1] Orlando, FL	0.9640	0.9752

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 Owensboro, KY	0.8344	0.8834
Daviess, KY		
6015 Panama City, FL	0.8865	0.9208
Bay, FL		
6020 Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8127	0.8676
Washington, OH		
Wood, WV		
6020 [2] Parkersburg-Marietta, WV-OH (OH Hospitals)	0.8613	0.9028
Washington, OH		
Wood, WV		
6080 [2] Pensacola, FL	0.8814	0.9172
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Pekin, IL	0.8739	0.9118
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 [1] Philadelphia, PA-NJ	1.0713	1.0483
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 [1] Phoenix-Mesa, AZ	0.9820	0.9876
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7962	0.8555
Jefferson, AR		
6280 [1] Pittsburgh, PA	0.9365	0.9561
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 [2] Pittsfield, MA	1.1288	1.0865
Berkshire, MA		
6340 Pocatello, ID	0.9674	0.9776
Bannock, ID		
6360 Ponce, PR	0.5169	0.6364
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9794	0.9858
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 [1] Portland-Vancouver, OR-WA	1.0684	1.0463
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 [1] Providence-Warwick-Pawtucket, RI	1.0854	1.0577
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	0.9984	0.9989
Utah, UT		
6560 [2] Pueblo, CO	0.9015	0.9315
Pueblo, CO		
6580 Punta Gorda, FL	0.9218	0.9458
Charlotte, FL		
6600 Racine, WI	0.9334	0.9539
Racine, WI		
6640 [1] Raleigh-Durham-Chapel Hill, NC	0.9990	0.9993
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8846	0.9195
Pennington, SD		
6680 Reading, PA	0.9295	0.9512
Berks, PA		
6690 Redding, CA	1.1135	1.0764
Shasta, CA		
6720 Reno, NV	1.0648	1.0439
Washoe, NV		
6740 Richland-Kennewick-Pasco, WA	1.1491	1.0998
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9477	0.9639
Charles City County, VA		
Chesterfield, VA		
Colonial Heights City, VA		
Dinwiddie, VA		
Goochland, VA		
Hanover, VA		
Henrico, VA		
Hopewell City, VA		
New Kent, VA		
Petersburg City, VA		
Powhatan, VA		
Prince George, VA		
Richmond City, VA		
6780 [1] Riverside-San Bernardino, CA	1.1365	1.0916
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8614	0.9029
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.2139	1.1420
Olmsted, MN		
6840 [1] Rochester, NY	0.9194	0.9441
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.9625	0.9742
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.9228	0.9465
Edgecombe, NC		
Nash, NC		
6920 [1] Sacramento, CA	1.1513	1.1013
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9650	0.9759
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9785	0.9852
Benton, MN		
Stearns, MN		
7000 [2] St. Joseph, MO	0.8026	0.8602
Andrew, MO		
Buchanan, MO		
7040 [1] St. Louis, MO-IL	0.8855	0.9201
Clinton, IL		
Jersey, IL		
Madison, IL		
Monroe, IL		
St. Clair, IL		
Franklin, MO		
Jefferson, MO		
Lincoln, MO		
St. Charles, MO		
St. Louis, MO		
St. Louis City, MO		
Warren, MO		
7080 Salem, OR	1.0367	1.0250
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.4623	1.2972
Monterey, CA		
7160 [1] Salt Lake City-Ogden, UT	0.9945	0.9962
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.8374	0.8856
Tom Green, TX		
7240 [1] San Antonio, TX	0.8753	0.9128
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 [1] San Diego, CA	1.1135	1.0764

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
San Diego, CA		
7360 [1] San Francisco, CA	1.4142	1.2679
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 [1] San Jose, CA	1.4145	1.2680
Santa Clara, CA		
7440 [1] San Juan-Bayamon, PR	0.4741	0.5998
Aguas Buenas, PR		
Barceloneta, PR		
Bayamon, PR		
Canovanas, PR		
Carolina, PR		
Catano, PR		
Ceiba, PR		
Comerio, PR		
Corozal, PR		
Dorado, PR		
Fajardo, PR		
Florida, PR		
Guaynabo, PR		
Humacao, PR		
Juncos, PR		
Los Piedras, PR		
Loiza, PR		
Luguillo, PR		
Manati, PR		
Morovis, PR		
Naguabo, PR		
Naranjito, PR		
Rio Grande, PR		
San Juan, PR		
Toa Alta, PR		
Toa Baja, PR		
Trujillo Alto, PR		
Vega Alta, PR		
Vega Baja, PR		
Yabucoa, PR		
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1271	1.0854
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0481	1.0327
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.3646	1.2372
Santa Cruz, CA		
7490 Santa Fe, NM	1.0712	1.0482
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.3046	1.1997
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9449	0.9619
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	0.9376	0.9568
Bryan, GA		
Chatham, GA		
Effingham, GA		
7560 Scranton--Wilkes-Barre--Hazleton, PA	0.8599	0.9018
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 [1] Seattle-Bellevue-Everett, WA	1.1474	1.0987
Island, WA		
King, WA		
Snohomish, WA		
7610 [2] Sharon, PA	0.8462	0.8919
Mercer, PA		
7620 [2] Sheboygan, WI	0.9162	0.9418
Sheboygan, WI		
7640 Sherman-Denison, TX	0.9255	0.9484
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.8987	0.9295
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA-NE	0.9046	0.9336
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD	0.9257	0.9485
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	0.9802	0.9864
St. Joseph, IN		
7840 Spokane, WA	1.0852	1.0576
Spokane, WA		
7880 Springfield, IL	0.8659	0.9061
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.8424	0.8892
Christian, MO		
Greene, MO		
Webster, MO		
8003 [2] Springfield, MA	1.1288	1.0865
Hampden, MA		
Hampshire, MA		
8050 State College, PA	0.8941	0.9262
Centre, PA		
8080 Steubenville-Weirton, OH-WV	0.8804	0.9165
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.0650	1.0441
San Joaquin, CA		
8140 [2] Sumter, SC	0.8607	0.9024
Sumter, SC		
8160 Syracuse, NY	0.9714	0.9803
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 Tacoma, WA	1.0940	1.0635
Pierce, WA		
8240 [2] Tallahassee, FL	0.8814	0.9172
Gadsden, FL		
Leon, FL		
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.9171	0.9425
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 [2] Terre Haute, IN	0.8755	0.9130
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana,AR-Texarkana, TX	0.8126	0.8675
Miller, AR		
Bowie, TX		
8400 Toledo, OH	0.9810	0.9869
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	0.9199	0.9444
Shawnee, KS		
8480 Trenton, NJ	1.0432	1.0294
Mercer, NJ		
8520 Tucson, AZ	0.8911	0.9241
Pima, AZ		
8560 Tulsa, OK	0.8332	0.8825
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
8600 Tuscaloosa, AL	0.8203	0.8731
Tuscaloosa, AL		
8640 Tyler, TX	0.9521	0.9669
Smith, TX		
8680 [2] Utica-Rome, NY	0.8542	0.8977
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.3421	1.2232
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.1096	1.0738
Ventura, CA		
8750 Victoria, TX	0.8756	0.9130
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	1.0031	1.0021
Cumberland, NJ		
8780 [2] Visalia-Tulare-Porterville, CA	0.9840	0.9890
Tulare, CA		
8800 Waco, TX	0.8088	0.8647
McLennan, TX		
8840 [1] Washington, DC-MD-VA-WV	1.0851	1.0575
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Clarke, VA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Culpeper, VA		
Fairfax, VA		
Fairfax City, VA		
Falls Church City, VA		
Fauquier, VA		
Fredericksburg City, VA		
King George, VA		
Loudoun, VA		
Manassas City, VA		
Manassas Park City, VA		
Prince William, VA		
Spotsylvania, VA		
Stafford, VA		
Warren, VA		
Berkeley, WV		
Jefferson, WV		
8920 Waterloo-Cedar Falls, IA	0.8902	0.9234
Black Hawk, IA		
8940 Wausau, WI	0.9782	0.9850
Marathon, WI		
8960 [1] West Palm Beach-Boca Raton, FL	0.9939	0.9958
Palm Beach, FL		
9000 [2] Wheeling, WV-OH (WV Hospitals)	0.7975	0.8565
Belmont, OH		
Marshall, WV		
Ohio, WV		
9000 [2] Wheeling, WV-OH (OH Hospitals)	0.8613	0.9028
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9520	0.9669
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.8498	0.8945
Archer, TX		
Wichita, TX		
9140 Williamsport, PA	0.8544	0.8978
Lycoming, PA		
9160 Wilmington-Newark, DE-MD	1.1173	1.0789
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9640	0.9752
New Hanover, NC		
Brunswick, NC		
9260 Yakima, WA	1.0569	1.0386
Yakima, WA		
9270 [2] Yolo, CA	0.9840	0.9890
Yolo, CA		
9280 York, PA	0.9026	0.9322
York, PA		
9320 Youngstown-Warren, OH	0.9358	0.9556
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
9340 Yuba City, CA	1.0276	1.0188
Sutter, CA		
Yuba, CA		
9360 Yuma, AZ	0.8589	0.9011
Yuma, AZ		

[1] Large Urban Area

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2003.

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7727	0.8381
Alaska	1.2293	1.1519
Arizona	0.8493	0.8942
Arkansas	0.7666	0.8336
California	0.9840	0.9890
Colorado	0.9015	0.9315
Connecticut	1.2394	1.1583
Delaware	0.9128	0.9394
Florida	0.8814	0.9172
Georgia	0.8230	0.8751
Hawaii	1.0255	1.0174
Idaho	0.8747	0.9124
Illinois	0.8204	0.8732
Indiana	0.8755	0.9130
Iowa	0.8315	0.8813
Kansas	0.7923	0.8526
Kentucky	0.8079	0.8641
Louisiana	0.7647	0.8322
Maine	0.8874	0.9215
Maryland	0.8946	0.9266
Massachusetts	1.1288	1.0865
Michigan	0.9013	0.9313
Minnesota	0.9151	0.9411
Mississippi	0.7680	0.8346
Missouri	0.8026	0.8602
Montana	0.8481	0.8933
Nebraska	0.8204	0.8732
Nevada	0.9577	0.9708
New Hampshire	0.9796	0.9860
New Jersey [1]	.....	.....
New Mexico	0.8872	0.9213
New York	0.8542	0.8977
North Carolina	0.8666	0.9066
North Dakota	0.7788	0.8427
Ohio	0.8613	0.9028
Oklahoma	0.7590	0.8279
Oregon	1.0303	1.0207
Pennsylvania	0.8462	0.8919
Puerto Rico	0.4356	0.5660
Rhode Island1	.....	.....
South Carolina	0.8607	0.9024
South Dakota	0.7815	0.8447
Tennessee	0.7877	0.8492
Texas	0.7827	0.8455
Utah	0.9312	0.9524
Vermont	0.9345	0.9547
Virginia	0.8504	0.8950
Washington	1.0179	1.0122
West Virginia	0.7975	0.8565
Wisconsin	0.9162	0.9418

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS—Continued

Nonurban area	Wage index	GAF
Wyoming	0.9007	0.9309

[1] All counties within the State are classified as urban.

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage index	GAF
Abilene, TX	0.7827	0.8455
Akron, OH	0.9600	0.9724
Albany, GA	1.0427	1.0290
Albuquerque, NM	0.9390	0.9578
Alexandria, LA	0.7883	0.8497
Allentown-Bethlehem-Easton, PA	0.9735	0.9818
Altoona, PA	0.9225	0.9463
Amarillo, TX	0.8884	0.9222
Anchorage, AK	1.2490	1.1645
Ann Arbor, MI	1.1103	1.0743
Anniston, AL	0.7910	0.8517
Asheville, NC	0.9575	0.9707
Athens, GA	1.0066	1.0045
Atlanta, GA	0.9889	0.9924
Augusta-Aiken, GA-SC	0.9887	0.9922
Austin-San Marcos, TX	0.9637	0.9750
Barnstable-Yarmouth, MA	1.2943	1.1932
Baton Rouge, LA	0.8190	0.8722
Bellingham, WA	1.1642	1.1097
Benton Harbor, MI	0.9106	0.9379
Bergen-Passaic, NJ	1.2207	1.1463
Billings, MT	0.9022	0.9319
Biloxi-Gulfport-Pascagoula, MS	0.8368	0.8851
Binghamton, NY	0.8462	0.8919
Birmingham, AL	0.9222	0.9460
Bismarck, ND	0.7972	0.8562
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1235	1.0830
Burlington, VT	0.9572	0.9705
Caguas, PR	0.4408	0.5707
Casper, WY	0.9586	0.9715
Champaign-Urbana, IL	0.9772	0.9843
Charleston-North Charleston, SC	0.9235	0.9470
Charleston, WV	0.8649	0.9054
Charlotte-Gastonia-Rock Hill, NC-SC	0.9743	0.9823
Charlottesville, VA	1.0120	1.0082
Chattanooga, TN-GA	0.8843	0.9192
Chicago, IL	1.0905	1.0611
Cincinnati, OH-KY-IN	0.9389	0.9577
Clarksville-Hopkinsville, TN-KY	0.8419	0.8888
Cleveland-Lorain-Elyria, OH	0.9670	0.9773
Columbia, MO	0.8515	0.8958
Columbia, SC	0.9194	0.9441
Columbus, GA-AL (GA Hospitals)	0.8230	0.8751

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Columbus, GA-AL (AL Hospitals)	0.7985	0.8572
Columbus, OH	0.9549	0.9689
Corpus Christi, TX	0.8729	0.9111
Dallas, TX	0.9998	0.9999
Davenport-Moline-Rock Island, IA-IL	0.8835	0.9187
Dayton-Springfield, OH	0.9282	0.9503
Denver, CO	1.0484	1.0329
Des Moines, IA	0.8827	0.9181
Detroit, MI	1.0448	1.0305
Dothan, AL	0.8158	0.8699
Dover, DE	0.9254	0.9483
Duluth-Superior, MN-WI	1.0368	1.0251
Eau Claire, WI	0.9162	0.9418
Elkhart-Goshen, IN	0.9516	0.9666
Erie, PA	0.8761	0.9134
Eugene-Springfield, OR	1.0944	1.0637
Fargo-Moorhead, ND-MN	0.9468	0.9633
Fayetteville, NC	0.8992	0.9298
Flagstaff, AZ-UT	1.0131	1.0090
Flint, MI	1.0963	1.0650
Florence, AL	0.7819	0.8449
Florence, SC	0.8780	0.9148
Fort Collins-Loveland, CO	1.0066	1.0045
Ft. Lauderdale, FL	1.0704	1.0477
Fort Pierce-Port St. Lucie, FL	0.9931	0.9953
Fort Smith, AR-OK	0.7738	0.8389
Fort Walton Beach, FL	0.9430	0.9606
Forth Worth-Arlington, TX	0.9446	0.9617
Gadsden, AL	0.8599	0.9018
Gainesville, FL	0.9871	0.9911
Grand Forks, ND-MN	0.9243	0.9475
Grand Junction, CO	0.9679	0.9779
Grand Rapids-Muskegon-Holland, MI	0.9548	0.9688
Great Falls, MT	0.8966	0.9280
Greeley, CO	0.9336	0.9540
Green Bay, WI	0.9668	0.9771
Greensboro-Winston-Salem-High Point, NC	0.9129	0.9395
Greenville, NC	0.9174	0.9427
Harrisburg-Lebanon-Carlisle, PA	0.9223	0.9461
Hartford, CT	1.1549	1.1036
Hattiesburg, MS	0.7680	0.8346
Hickory-Morganton-Lenoir, NC	0.8926	0.9251
Houston, TX	0.9792	0.9857
Huntington-Ashland, WV-KY-OH	0.9167	0.9422
Huntsville, AL	0.8771	0.9141
Indianapolis, IN	0.9717	0.9805
Iowa City, IA	0.9442	0.9614
Jackson, MS	0.8607	0.9024
Jackson, TN	0.9002	0.9305
Jacksonville, FL	0.9237	0.9471
Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8504	0.8950
Johnson City-Kingsport-Bristol, TN-VA (KY Hospitals)	0.8337	0.8829
Jonesboro, AR (AR Hospitals)	0.7843	0.8467
Jonesboro, AR (MO Hospitals)	0.8026	0.8602
Joplin, MO	0.8613	0.9028
Kalamazoo-Battlecreek, MI	1.0400	1.0272
Kansas City, KS-MO	0.9736	0.9818
Knoxville, TN	0.8970	0.9283
Kokomo, IN	0.9038	0.9331
Lafayette, LA	0.8316	0.8814
Lakeland-Winter Haven, FL	0.9357	0.9555
Las Vegas, NV-AZ	1.1521	1.1018
Lawton, OK	0.8077	0.8639
Lexington, KY	0.8581	0.9005
Lima, OH	0.9483	0.9643
Lincoln, NE	0.9711	0.9801
Little Rock-North Little Rock, AR	0.8951	0.9269
Longview-Marshall, TX	0.8629	0.9040
Los Angeles-Long Beach, CA	1.2011	1.1337
Louisville, KY-IN	0.9163	0.9419
Lubbock, TX	0.9646	0.9756
Lynchburg, VA	0.8909	0.9239
Macon, GA	0.9250	0.9480
Madison, WI	1.0467	1.0317
Medford-Ashland, OR	1.0303	1.0207
Memphis, TN-AR-MS	0.8712	0.9099
Miami, FL	0.9815	0.9873
Milwaukee-Waukesha, WI	0.9893	0.9927
Minneapolis-St. Paul, MN-WI	1.0903	1.0610
Missoula, MT	0.9047	0.9337
Mobile, AL	0.8110	0.8664
Modesto, CA	1.0498	1.0338
Monmouth-Ocean, NJ	1.0814	1.0551
Monroe, LA	0.8137	0.8683
Montgomery, AL	0.7734	0.8386
Nashville, TN	0.9375	0.9568
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2459	1.1625
New London-Norwich, CT	1.1626	1.1087
New Orleans, LA	0.9046	0.9336
New York, NY	1.4220	1.2726
Newark, NJ	1.1406	1.0943
Newburgh, NY-PA	1.0747	1.0506
Norfolk-Virginia Beach-Newport News, VA-NC	0.8666	0.9066
Oakland, CA	1.5185	1.3312
Odessa-Midland, TX	0.9180	0.9431
Oklahoma City, OK	0.8900	0.9233
Omaha, NE-IA	0.9978	0.9985
Orange County, CA	1.1594	1.1066
Orlando, FL	0.9640	0.9752
Peoria-Pekin, IL	0.8739	0.9118
Philadelphia, PA-NJ	1.0713	1.0483
Phoenix-Mesa, AZ	0.9820	0.9876
Pine Bluff, AR	0.7798	0.8434
Pittsburgh, PA	0.9224	0.9462
Pittsfield, MA	0.9863	0.9906
Pocatello, ID	0.9674	0.9776
Portland, ME	0.9620	0.9738
Portland-Vancouver, OR-WA	1.0684	1.0463
Provo-Orem, UT	0.9984	0.9989
Raleigh-Durham-Chapel Hill, NC	0.9990	0.9993
Rapid City, SD	0.8846	0.9195
Reading, PA	0.9108	0.9380
Redding, CA	1.1135	1.0764
Reno, NV	1.0466	1.0317
Richland-Kennewick-Pasco, WA	1.0800	1.0541
Richmond-Petersburg, VA	0.9477	0.9639
Roanoke, VA	0.8614	0.9029
Rochester, MN	1.2139	1.1420
Rockford, IL	0.9399	0.9584
Sacramento, CA	1.1513	1.1013
Saginaw-Bay City-Midland, MI	0.9543	0.9685
St. Cloud, MN	0.9785	0.9852
St. Joseph, MO	0.8240	0.8758
St. Louis, MO-IL	0.8855	0.9201
Salinas, CA	1.4623	1.2972
Salt Lake City-Ogden, UT	0.9945	0.9962
San Antonio, TX	0.8753	0.9128
San Diego, CA	1.1135	1.0764
Santa Fe, NM	0.9891	0.9925
Santa Rosa, CA	1.2761	1.1817
Sarasota-Bradenton, FL	0.9449	0.9619
Savannah, GA	0.9376	0.9568
Seattle-Bellevue-Everett, WA	1.1474	1.0987
Sherman-Denison, TX	0.9008	0.9310
Shreveport-Bossier City, LA	0.8987	0.9295
Sioux City, IA-NE	0.8647	0.9052
Sioux Falls, SD	0.9059	0.9346
South Bend, IN	0.9802	0.9864
Spokane, WA	1.0663	1.0449
Springfield, IL	0.8659	0.9061
Springfield, MO	0.8153	0.8695
Stockton-Lodi, CA	1.0650	1.0441
Syracuse, NY	0.9612	0.9733
Tampa-St. Petersburg-Clearwater, FL	0.9171	0.9425
Texarkana,AR-Texarkana, TX	0.8126	0.8675
Toledo, OH	0.9810	0.9869
Topeka, KS	0.9031	0.9326
Tucson, AZ	0.8911	0.9241
Tulsa, OK	0.8332	0.8825
Tuscaloosa, AL	0.8203	0.8731
Tyler, TX	0.9195	0.9441
Vallejo-Fairfield-Napa, CA	1.3421	1.2232
Victoria, TX	0.8756	0.9130
Waco, TX	0.8088	0.8647
Washington, DC-MD-VA-WV	1.0851	1.0575

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Waterloo-Cedar Falls, IA	0.8902	0.9234
Wausau, WI	0.9782	0.9850
West Palm Beach-Boca Raton, FL	0.9939	0.9958
Wichita, KS	0.9179	0.9430
Wichita Falls, TX	0.8498	0.8945
Wilmington-Newark, DE-MD	1.0862	1.0583
Wilmington, NC	0.9425	0.9603

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
York, PA	0.9026	0.9322
Youngstown-Warren, OH	0.9358	0.9556
Rural Alabama	0.7727	0.8381
Rural Florida	0.8814	0.9172
Rural Illinois (IA Hospitals)	0.8315	0.8813
Rural Illinois (MO Hospitals)	0.8204	0.8732
Rural Kentucky	0.8079	0.8641

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Rural Louisiana	0.7647	0.8322
Rural Michigan	0.9013	0.9313
Rural Minnesota	0.9151	0.9411
Rural Missouri	0.8026	0.8602
Rural Montana	0.8481	0.8933
Rural Nebraska	0.8204	0.8732
Rural Nevada	0.9117	0.9387
Rural Texas	0.7827	0.8455
Rural Washington	1.0179	1.0122
Rural Wyoming	0.9007	0.9309

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF)

Area	Wage index	GAF	Wage index—reclass. hospitals	GAF—reclass. hospitals
Aguadilla, PR	0.9679	0.9779		
[1] Arecibo, PR	0.9192	0.9439		
Caguas, PR	0.9302	0.9517	0.9302	0.9517
Mayaguez, PR	1.0369	1.0251		
Ponce, PR	1.0907	1.0613		
San Juan-Bayamon, PR	1.0004	1.0003		
Rural Puerto Rico	0.9192	0.9439		

[1] Hospitals geographically located in the area are assigned the Rural Puerto Rico wage index for FY 2003.

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties)	Wage index
0040 Abilene, TX	0.7820
Taylor, TX	
0060 Aguadilla, PR	0.4587
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9599
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0594
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8542
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9315
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.7859
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	0.9735
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.9224

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Blair, PA	
0320 Amarillo, TX Potter, TX	0.9034
Randall, TX	
0380 Anchorage, AK	1.2358
Anchorage, AK	
0440 Ann Arbor, MI	1.1103
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8044
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.9162
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4356
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9876
Buncombe, NC	
Madison, NC	
0500 Athens, GA	1.0210
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA	0.9991
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Clayton, GA	
Cobb, GA	
Coweta, GA	
DeKalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic-Cape May, NJ	1.1016
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8325
Lee, AL	
0600 Augusta-Aiken, GA-SC	1.0264
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX	0.9637
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Williamson, TX	
0680 Bakersfield, CA	0.9898
Kern, CA	
0720 Baltimore, MD	0.9929
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME	0.9664
Penobscot, ME	
0743 Barnstable-Yarmouth, MA	1.3202
Barnstable, MA	
0760 Baton Rouge, LA	0.8294
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8324
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.2281
Whatcom, WA	
0870 Benton Harbor, MI	0.9041
Berrien, MI	
0875 Bergen-Passaic, NJ	1.2150
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.9022
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8757
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.8542
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.9221
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7972
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8906
Monroe, IN	
1040 Bloomington-Normal, IL	0.9109
McLean, IL	
1080 Boise City, ID	0.9310
Ada, ID	
Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals)	1.1288
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	
Rockingham, NH	
Strafford, NH	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
1125 Boulder-Longmont, CO	0.9689
Boulder, CO	
1145 Brazoria, TX	0.8535
Brazoria, TX	
1150 Bremerton, WA	1.0944
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	0.8880
Cameron, TX	
1260 Bryan-College Station, TX	0.8821
Brazos, TX	
1280 Buffalo-Niagara Falls, NY	0.9365
Erie, NY	
Niagara, NY	
1303 Burlington, VT	1.0052
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4371
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.8931
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9689
Natrona, WY	
1360 Cedar Rapids, IA	0.9056
Linn, IA	
1400 Champaign-Urbana, IL	1.0635
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9235
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.8897
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC-SC	0.9850
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0437
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.8976
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY	0.9007
Laramie, WY	
1600 Chicago, IL	1.1044
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	0.9839
Butte, CA	
1640 Cincinnati, OH-KY-IN	0.9380
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN-KY	0.8405
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH	0.9670
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9915
El Paso, CO	
1740 Columbia, MO	0.8495
Boone, MO	
1760 Columbia, SC	0.9306
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL Russell, AL	0.8374
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH	0.9751
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8728
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1452
Benton, OR	
1900 Cumberland, MD-WV (WV Hospital)	0.7975
Allegany, MD	
Mineral, WV	
1920 Dallas, TX	0.9998
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.8859
Danville City, VA	
Pittsylvania, VA	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
1960 Davenport-Moline-Rock Island, IA-IL	0.8834
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9282
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9062
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8973
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.8204
Macon, IL	
2080 Denver, CO	1.0600
Adams, CO	
Arapahoe, CO	
Broomfield, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.8790
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI	1.0448
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.8137
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9356
Kent, DE	
2200 Dubuque, IA	0.8795
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0367
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0684
Dutchess, NY	
2290 Eau Claire, WI	0.9162
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9265
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9722
Elkhart, IN	
2335 Elmira, NY	0.8542
Chemung, NY	
2340 Enid, OK	0.8376
Garfield, OK	
2360 Erie, PA	0.8925
Erie, PA	
2400 Eugene-Springfield, OR	1.0944
Lane, OR	
2440 Evansville-Henderson, IN-KY (IN Hospitals)	0.8754
Posey, IN	
Vanderburgh, IN	
Warrick, IN	
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9684
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8889
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8099
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.0682
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.1135
Genesee, MI	
2650 Florence, AL	0.7792
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8780
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0066
Larimer, CO	
2680 Ft. Lauderdale, FL	1.0296
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9680
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	0.9823
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.7895
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.9693
Okaloosa, FL	
2760 Fort Wayne, IN	0.9457
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Forth Worth-Arlington, TX	0.9445
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0216
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8505
Etowah, AL	
2900 Gainesville, FL	0.9871
Alachua, FL	
2920 Galveston-Texas City, TX	0.9465
Galveston, TX	
2960 Gary, IN	0.9584
Lake, IN	
Porter, IN	
2975 Glens Falls, NY	0.8542
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8891
Wayne, NC	
2985 Grand Forks, ND-MN	0.8897
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9456
Mesa, CO	
3000 Grand Rapids-Muskegon-Holland, MI	0.9525
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8950
Cascade, MT	
3060 Greeley, CO	0.9236
Weld, CO	
3080 Green Bay, WI	0.9502
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC	0.9282
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NCGuilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9100
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9122
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9267
Washington, MD	
3200 Hamilton-Middletown, OH	0.9418
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9223
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT	1.2393
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 2Hattiesburg, MS	0.7680
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9028
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1457
Honolulu, HI	
3350 Houma, LA	0.8384
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX	0.9892
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9635
Boyd, KY	
Carter, KY	
Greenup, KY	
Lawrence, OH	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.8902
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN	0.9717
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9587
Johnson, IA	
3520 Jackson, MI	0.9532
Jackson, MI	
3560 Jackson, MS	0.8607
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.9275
Madison, TN	
Chester, TN	
3600 Jacksonville, FL	0.9381
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.8665
Onslow, NC	
3610 Jamestown, NY	0.8542
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9849
Rock, WI	
3640 Jersey City, NJ	1.1189
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8268
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8461
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7749
Craighead, AR	
3710 Joplin, MO	0.8613
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0594
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	0.8204
Kankakee, IL	
3760 Kansas City, KS-MO	0.9736
Johnson, KS	
Leavenworth, KS	
Miami, KS	
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9686
Kenosha, WI	
3810 Killeen-Temple, TX	0.9569
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8970
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.8971
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9400
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8475
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9278
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7965
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.9357
Polk, FL	
4000 Lancaster, PA	0.9078
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9726
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8472
Webb, TX	
4100 Las Cruces, NM	0.8872
Dona Ana, NM	
4120 Las Vegas, NV-AZ	1.1520
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.7922
Douglas, KS	
4200 Lawton, OK	0.8315
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9179
Androscoggin, ME	
4280 Lexington, KY	0.8581
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9483
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	0.9892
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.9096
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.8628
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA	1.2001
Los Angeles, CA	
4520 1Louisville, KY-IN	0.9276
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.9645
Lubbock, TX	
4640 Lynchburg, VA	0.9218
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.9204
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0466
Dane, WI	
4800 Mansfield, OH	0.8899
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4914
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8428
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0498
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	1.0253
Brevard, Fl	
4920 Memphis, TN-AR-MS	0.8920
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	0.9839
Merced, CA	
5000 Miami, FL	0.9802
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ	1.1213
Hunterdon, NJ	
Middlesex, NJ	
Somerset, NJ	
5080 Milwaukee-Waukesha, WI	0.9892
Milwaukee, WI	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St. Paul, MN-WI	1.0903
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St. Croix, WI	
5140 Missoula, MT	0.9157
Missoula, MT	
5160 Mobile, AL	0.8108
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.0498
Stanislaus, CA	
5190 Monmouth-Ocean, NJ	1.0674
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.8137
Ouachita, LA	
5240 Montgomery, AL	0.7733
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.9284
Delaware, IN	
5330 Myrtle Beach, SC	0.8976
Horry, SC	
5345 Naples, FL	0.9754
Collier, FL	
5360 Nashville, TN	0.9577
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY	1.3357
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury-	1.2408
Danbury, CT	
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT	1.2393
New London, CT	
5560 New Orleans, LA	0.9046
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	
St. Tammany, LA	
5600 New York, NY	1.4414
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ	1.1381
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1386
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA-NC	0.8574
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City VA	
Williamsburg City, VA	
York, VA	
5775 Oakland, CA	1.5071
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9402
Marion, FL	
5800 Odessa-Midland, TX	0.9397
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK	0.8900
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.0959
Thurston, WA	
5920 Omaha, NE-IA	0.9978
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA	1.1474
Orange, CA	
5960 Orlando, FL	0.9639
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8344
Daviess, KY	
6015 Panama City, FL	0.8865
Bay, FL	
6020 Parkersburg-Marietta, WV-OH	0.8126
Washington, OH	
Wood, WV	
6080 Pensacola, FL	0.8814
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8739
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA-NJ	1.0713
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ	0.9820
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7962
Jefferson, AR	
6280 Pittsburgh, PA	0.9365
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA	1.1288
Berkshire, MA	
6340 Pocatello, ID	0.9372
Bannock, ID	
6360 Ponce, PR	0.5169
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9794
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR-WA	1.0667
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI	1.0854
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	0.9984
Utah, UT	
6560 Pueblo, CO	0.9015
Pueblo, CO	
6580 Punta Gorda, FL	0.9218
Charlotte, FL	
6600 Racine, WI	0.9334
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC	0.9990

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8846
Pennington, SD	
6680 Reading, PA	0.9295
Berks, PA	
6690 Redding, CA	1.1135
Shasta, CA	
6720 Reno, NV	1.0648
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.1491
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9476
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 Riverside-San Bernardino, CA	1.1365
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8614
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.2139
Olmsted, MN	
6840 Rochester, NY	0.9194
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9625
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9228
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA	1.1500
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9650
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9700
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO	0.8020

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Andrew, MO	
Buchanan, MO	
7040 St. Louis, MO-IL	0.8855
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
7080 Salem, OR	1.0367
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4622
Monterey, CA	
7160 Salt Lake City-Ogden, UT	0.9945
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8374
Tom Green, TX	
7240 San Antonio, TX	0.8753
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA	1.1131
San Diego, CA	
7360 San Francisco, CA	1.4142
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA	1.4145
Santa Clara, CA	
7440 San Juan-Bayamon, PR	0.4741
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1271
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0481
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.3645
Santa Cruz, CA	
7490 Santa Fe, NM	1.0712
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.3045
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9425
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9376
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton--Wilkes-Barre--Hazleton, PA	0.8599
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA	1.1474
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.8461
Mercer, PA	
7620 Sheboygan, WI	0.9162
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9255
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.8987
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.9046
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9257
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9802
St. Joseph, IN	
7840 Spokane, WA	1.0852
Spokane, WA	
7880 Springfield, IL	0.8659
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8424
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.1288
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.8941
Centre, PA	
8080 Steubenville-Weirton, OH-WV (WV Hospitals)	0.8803
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0505
San Joaquin, CA	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
8140 Sumter, SC	0.8607
Sumter, SC	
8160 Syracuse, NY	0.9714
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.0940
Pierce, WA	
8240 Tallahassee, FL	0.8814
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL	0.9065
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.8754
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana,AR-Texarkana, TX	0.8088
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9810
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9198
Shawnee, KS	
8480 Trenton, NJ	1.0432
Mercer, NJ	
8520 Tucson, AZ	0.8911
Pima, AZ	
8560 Tulsa, OK	0.8332
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8130
Tuscaloosa, AL	
8640 Tyler, TX	0.9521
Smith, TX	
8680 Utica-Rome, NY	0.8542
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3354
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.1095
Ventura, CA	
8750 Victoria, TX	0.8756
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0031
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	0.9839
Tulare, CA	
8800 Waco, TX	0.8073
McLennan, TX	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
8840 Washington, DC-MD-VA-WV	1.0851
District of Columbia, DC	
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpeper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8315
Black Hawk, IA	
8940 Wausau, WI	0.9782
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL	0.9939
Palm Beach, FL	
9000 Wheeling, WV-OH	0.7975
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9520
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.8498
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8544
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.1173
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9640
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0568
Yakima, WA	
9270 Yolo, CA	0.9839
Yolo, CA	
9280 York, PA	0.9026
York, PA	
9320 Youngstown-Warren, OH	0.9358
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0276
Sutter, CA	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Yuba, CA	
9360 Yuma, AZ	0.8589
Yuma, AZ	

TABLE 4H.—PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7660
Alaska	1.2293
Arizona	0.8493
Arkansas	0.7666
California	0.9839
Colorado	0.9015
Connecticut	1.2393
Delaware	0.9128
Florida	0.8814
Georgia	0.8230
Hawaii	1.0255
Idaho	0.8747
Illinois	0.8204
Indiana	0.8754
Iowa	0.8315
Kansas	0.7922
Kentucky	0.8079
Louisiana	0.7566
Maine	0.8874
Maryland	0.8945
Massachusetts	1.1288
Michigan	0.9000
Minnesota	0.9151
Mississippi	0.7680
Missouri	0.8020
Montana	0.8481
Nebraska	0.8204
Nevada	0.9577
New Hampshire	0.9796
New Jersey [1]	.....
New Mexico	0.8872
New York	0.8542
North Carolina	0.8665
North Dakota	0.7788
Ohio	0.8613
Oklahoma	0.7590
Oregon	1.0302
Pennsylvania	0.8461
Puerto Rico	0.4356
Rhode Island [1]	.....
South Carolina	0.8607
South Dakota	0.7815
Tennessee	0.7877
Texas	0.7820
Utah	0.9528
Vermont	0.9345
Virginia	0.8504
Washington	1.0179
West Virginia	0.7975
Wisconsin	0.9162
Wyoming	0.9007

[1] All counties within the State are classified as urban.

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)*

[Explanation of footnotes: * Medicare Data Have Been Supplemented by Data From 19 States for Low Volume DRGS. ** DRGS 469 and 470 Contain Cases Which Could not be Assigned to Valid DRGS. Note: Geometric Mean is Used Only to Determine Payment for Transfer Cases. Note: Arithmetic Mean is Presented for Informational Purposes only. Note: Relative Weights are Based on Medicare Patient Data and May Not be Appropriate for Other Patients.]

DRG	MDC	Type	DRG Title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
1	01	SURG	CRANIOTOMY AGE >17 W CC	3.7399	8.1	11.2
2	01	SURG	CRANIOTOMY AGE >17 W/O CC	1.9730	4.0	5.2
3	01	SURG	*CRANIOTOMY AGE 0-17	1.9504	12.7	12.7
4	01	SURG	SPINAL PROCEDURES	2.3184	4.5	7.2
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.3837	2.1	3.1
6	01	SURG	CARPAL TUNNEL RELEASE	0.8242	2.1	2.9
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.5807	6.5	9.8
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.4967	1.9	2.8
9	01	MED	SPINAL DISORDERS & INJURIES	1.3769	4.6	6.6
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2598	4.8	6.6
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	0.8689	3.0	4.0
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.8918	4.4	5.9
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.7968	4.1	5.0
14	01	MED	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1.2943	4.8	6.2
15	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.9858	4.0	5.0
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.2413	4.7	6.2
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.6672	2.5	3.1
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.9727	4.2	5.4
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.6944	2.8	3.5
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.8156	8.0	10.7
21	01	MED	VIRAL MENINGITIS	1.5369	5.0	6.6
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	1.0343	3.9	5.0
23	01	MED	NONTRAUMATIC STUPOR & COMA	0.8220	3.1	4.3
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	0.9978	3.6	4.9
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	0.6085	2.5	3.2
26	01	MED	SEIZURE & HEADACHE AGE 0-17	0.7847	2.5	4.6
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3164	3.1	5.0
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3447	4.5	6.3
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.7086	2.7	3.6
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.3299	2.0	2.0
31	01	MED	CONCUSSION AGE >17 W CC	0.8806	3.0	4.1
32	01	MED	CONCUSSION AGE >17 W/O CC	0.5336	1.9	2.4
33	01	MED	*CONCUSSION AGE 0-17	0.2072	1.6	1.6
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9978	3.7	5.0
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6385	2.5	3.2
36	02	SURG	RETINAL PROCEDURES	0.6830	1.2	1.5
37	02	SURG	ORBITAL PROCEDURES	1.0568	2.6	3.8
38	02	SURG	PRIMARY IRIS PROCEDURES	0.5418	1.9	2.5
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.5936	1.5	1.9
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.8756	2.5	3.6
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.3358	1.6	1.6
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.6593	1.7	2.4
43	02	MED	HYPHEMA	0.4992	2.4	3.0
44	02	MED	ACUTE MAJOR EYE INFECTIONS	0.6409	4.1	5.1
45	02	MED	NEUROLOGICAL EYE DISORDERS	0.7080	2.6	3.2
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	0.7832	3.4	4.6
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.5209	2.5	3.2
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0-17	0.2958	2.9	2.9
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.7796	3.3	4.6
50	03	SURG	SIALOADENECTOMY	0.8332	1.5	1.8
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.9461	1.9	3.1
52	03	SURG	CLEFT LIP & PALATE REPAIR	0.7983	1.5	1.9
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.2005	2.1	3.4
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0-17	0.4795	3.2	3.2
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	0.9595	1.9	3.1
56	03	SURG	RHINOPLASTY	0.9666	2.0	3.0
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	0.9927	2.4	3.7
58	03	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17.	0.2722	1.5	1.5
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.7528	1.8	2.6
60	03	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2073	1.5	1.5
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.3065	2.9	4.8
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.2936	1.3	1.3
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.4363	3.0	4.5
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.3119	4.4	6.6

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)*—Continued

[Explanation of footnotes: * Medicare Data Have Been Supplemented by Data From 19 States for Low Volume DRGS. ** DRGS 469 and 470 Contain Cases Which Could not be Assigned to Valid DRGS. Note: Geometric Mean is Used Only to Determine Payment for Transfer Cases. Note: Arithmetic Mean is Presented for Informational Purposes only. Note: Relative Weights are Based on Medicare Patient Data and May Not be Appropriate for Other Patients.]

DRG	MDC	Type	DRG Title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
65	03	MED	DYSEQUILIBRIUM	0.5484	2.3	2.8
66	03	MED	EPISTAXIS	0.5653	2.4	3.1
67	03	MED	EPIGLOTTITIS	0.7774	2.8	3.6
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	0.6696	3.1	3.8
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	0.5025	2.4	3.0
70	03	MED	OTITIS MEDIA & URI AGE 0-17	0.4638	2.8	3.5
71	03	MED	LARYNGOTRACHEITIS	0.6895	2.8	3.4
72	03	MED	NASAL TRAUMA & DEFORMITY	0.7185	2.6	3.6
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.7961	3.2	4.4
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.3337	2.1	2.1
75	04	SURG	MAJOR CHEST PROCEDURES	3.1077	7.7	10.1
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.8647	8.5	11.5
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.2097	3.5	4.9
78	04	MED	PULMONARY EMBOLISM	1.3022	5.7	6.7
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6193	6.7	8.5
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.8757	4.4	5.5
81	04	MED	*RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.5107	6.1	6.1
82	04	MED	RESPIRATORY NEOPLASMS	1.3943	5.2	7.0
83	04	MED	MAJOR CHEST TRAUMA W CC	0.9728	4.3	5.5
84	04	MED	MAJOR CHEST TRAUMA W/O CC	0.5125	2.6	3.2
85	04	MED	PLEURAL EFFUSION W CC	1.2145	4.8	6.4
86	04	MED	PLEURAL EFFUSION W/O CC	0.6963	2.9	3.8
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3658	4.8	6.4
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.9028	4.1	5.1
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0420	4.8	5.9
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.6262	3.4	4.0
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.7034	3.2	4.0
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.2273	5.0	6.4
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	0.7306	3.3	4.1
94	04	MED	PNEUMOTHORAX W CC	1.1624	4.7	6.4
95	04	MED	PNEUMOTHORAX W/O CC	0.5940	2.9	3.7
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	0.7530	3.7	4.6
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5593	2.9	3.5
98	04	MED	BRONCHITIS & ASTHMA AGE 0-17	0.9540	3.7	5.1
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	0.7034	2.4	3.2
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.5350	1.7	2.1
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8592	3.3	4.4
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.5467	2.0	2.6
103	PRE	SURG	HEART TRANSPLANT	20.5419	30.5	52.1
104	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH.	7.9916	12.3	14.4
105	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH.	5.8063	8.3	10.0
106	05	SURG	CORONARY BYPASS W PTCA	7.4425	9.6	11.4
107	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.3850	9.2	10.5
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.4758	7.8	10.3
109	05	SURG	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	3.9795	6.8	7.7
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1218	6.5	9.1
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.4580	3.5	4.4
112	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	3.0261	10.4	13.4
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.6551	6.2	8.5
115	05	SURG	PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GN.	3.4466	5.9	8.3
116	05	SURG	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	2.3078	3.2	4.5
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.3345	2.6	4.2
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5689	1.9	2.9
119	05	SURG	VEIN LIGATION & STRIPPING	1.3045	3.0	5.1
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.2383	5.3	8.8
121	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	1.6216	5.3	6.6
122	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	1.0679	3.0	3.8
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5529	2.8	4.7

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)*—Continued

[Explanation of footnotes: * Medicare Data Have Been Supplemented by Data From 19 States for Low Volume DRGS. ** DRGS 469 and 470 Contain Cases Which Could not be Assigned to Valid DRGS. Note: Geometric Mean is Used Only to Determine Payment for Transfer Cases. Note: Arithmetic Mean is Presented for Informational Purposes only. Note: Relative Weights are Based on Medicare Patient Data and May Not be Appropriate for Other Patients.]

DRG	MDC	Type	DRG Title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.4415	3.3	4.4
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	1.0844	2.1	2.7
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.7280	9.5	12.2
127	05	MED	HEART FAILURE & SHOCK	1.0039	4.1	5.3
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	0.7230	4.7	5.5
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0767	1.8	2.8
130	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	0.9439	4.5	5.7
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5706	3.3	4.1
132	05	MED	ATHEROSCLEROSIS W CC	0.6564	2.3	2.9
133	05	MED	ATHEROSCLEROSIS W/O CC	0.5353	1.8	2.3
134	05	MED	HYPERTENSION	0.5877	2.5	3.2
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9011	3.3	4.5
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	0.5711	2.1	2.6
137	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8139	3.3	3.3
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8274	3.1	4.0
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5126	2.0	2.5
140	05	MED	ANGINA PECTORIS	0.5382	2.1	2.6
141	05	MED	SYNCOPE & COLLAPSE W CC	0.7296	2.8	3.6
142	05	MED	SYNCOPE & COLLAPSE W/O CC	0.5613	2.1	2.6
143	05	MED	CHEST PAIN	0.5391	1.7	2.1
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.1992	3.8	5.5
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.5899	2.1	2.7
146	06	SURG	RECTAL RESECTION W CC	2.7203	8.8	10.2
147	06	SURG	RECTAL RESECTION W/O CC	1.5562	5.8	6.4
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.4503	10.2	12.3
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5251	5.9	6.5
150	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.8484	9.1	11.2
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.3296	4.5	5.7
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9506	6.9	8.3
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.1770	4.8	5.4
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.1533	9.8	13.3
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3082	3.0	4.0
156	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	0.8382	6.0	6.0
157	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.2612	3.9	5.6
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	0.6503	2.0	2.5
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.3612	3.7	5.1
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	0.8065	2.2	2.6
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.1264	2.8	4.2
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.6325	1.6	1.9
163	06	SURG	*HERNIA PROCEDURES AGE 0-17	0.6877	2.1	2.1
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.2962	7.0	8.3
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2609	4.0	4.6
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4690	3.7	4.9
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.9088	2.1	2.5
168	03	SURG	MOUTH PROCEDURES W CC	1.3038	3.3	4.9
169	03	SURG	MOUTH PROCEDURES W/O CC	0.7444	1.8	2.3
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8555	7.6	11.1
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.2025	3.1	4.3
172	06	MED	DIGESTIVE MALIGNANCY W CC	1.3624	5.1	7.0
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	0.7540	2.7	3.7
174	06	MED	G.I. HEMORRHAGE W CC	0.9952	3.9	4.8
175	06	MED	G.I. HEMORRHAGE W/O CC	0.5551	2.5	2.9
176	06	MED	COMPLICATED PEPTIC ULCER	1.0826	4.1	5.3
177	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	0.9170	3.7	4.5
178	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	0.6806	2.6	3.1
179	06	MED	INFLAMMATORY BOWEL DISEASE	1.0786	4.6	6.0
180	06	MED	G.I. OBSTRUCTION W CC	0.9443	4.1	5.4
181	06	MED	G.I. OBSTRUCTION W/O CC	0.5331	2.8	3.4

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)*—Continued

[Explanation of footnotes: * Medicare Data Have Been Supplemented by Data From 19 States for Low Volume DRGS. ** DRGS 469 and 470 Contain Cases Which Could not be Assigned to Valid DRGS. Note: Geometric Mean is Used Only to Determine Payment for Transfer Cases. Note: Arithmetic Mean is Presented for Informational Purposes only. Note: Relative Weights are Based on Medicare Patient Data and May Not be Appropriate for Other Patients.]

DRG	MDC	Type	DRG Title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
182	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	0.7986	3.3	4.4
183	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	0.5723	2.3	2.9
184	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.4836	2.3	2.8
185	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	0.8986	3.3	4.7
186	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17.	0.3195	2.9	2.9
187	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	0.8665	3.1	4.2
188	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0985	4.1	5.6
189	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5825	2.4	3.1
190	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.7006	3.3	4.8
191	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.3282	9.8	13.8
192	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.7144	4.7	6.1
193	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.4245	10.5	12.8
194	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.6033	5.5	6.9
195	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	3.0071	8.6	10.4
196	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6046	4.6	5.4
197	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.4857	7.3	9.0
198	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.2250	3.8	4.4
199	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.4345	7.0	9.9
200	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	2.9740	6.5	10.5
201	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.7858	10.4	14.5
202	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.2941	4.8	6.4
203	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3555	5.0	6.8
204	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.1858	4.4	5.8
205	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.2003	4.6	6.2
206	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.7061	3.0	3.9
207	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1405	4.0	5.3
208	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	0.6531	2.3	2.9
209	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	2.0782	4.5	5.0
210	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.8622	6.1	7.0
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2848	4.6	5.0
212	08	SURG	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	0.8418	11.1	11.1
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.8694	6.6	9.2
214	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
215	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.2225	6.6	9.6
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS.	3.0272	9.1	13.5
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC.	1.5475	4.3	5.5
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC.	1.0266	2.7	3.2
220	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17.	0.5807	5.3	5.3
221	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
222	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	1.0261	2.1	2.9
224	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC.	0.7859	1.6	1.9
225	08	SURG	FOOT PROCEDURES	1.1476	3.5	5.0
226	08	SURG	SOFT TISSUE PROCEDURES W CC	1.5730	4.6	6.7
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	0.8152	2.1	2.7

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)*—Continued

[Explanation of footnotes: * Medicare Data Have Been Supplemented by Data From 19 States for Low Volume DRGS. ** DRGS 469 and 470 Contain Cases Which Could not be Assigned to Valid DRGS. Note: Geometric Mean is Used Only to Determine Payment for Transfer Cases. Note: Arithmetic Mean is Presented for Informational Purposes only. Note: Relative Weights are Based on Medicare Patient Data and May Not be Appropriate for Other Patients.]

DRG	MDC	Type	DRG Title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
228	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC.	1.1379	2.6	4.1
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.7004	1.7	2.2
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.2763	3.3	5.1
231	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.4007	3.1	4.9
232	08	SURG	ARTHROSCOPY	1.0011	1.8	2.7
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.1159	5.1	7.8
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC ..	1.2428	2.3	3.2
235	08	MED	FRACTURES OF FEMUR	0.7692	3.8	5.1
236	08	MED	FRACTURES OF HIP & PELVIS	0.7350	3.9	4.9
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.5840	2.9	3.6
238	08	MED	OSTEOMYELITIS	1.4039	6.6	8.9
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	1.0065	4.9	6.3
240	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.3372	5.0	6.7
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	0.6511	3.1	3.9
242	08	MED	SEPTIC ARTHRITIS	1.1281	5.1	6.7
243	08	MED	MEDICAL BACK PROBLEMS	0.7418	3.7	4.7
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.7072	3.7	4.7
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4698	2.7	3.4
246	08	MED	NON-SPECIFIC ARTHROPATHIES	0.5658	2.9	3.8
247	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	0.5733	2.6	3.4
248	08	MED	TENDONITIS, MYOSITIS & BURSITIS	0.8357	3.8	4.9
249	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	0.6902	2.5	3.7
250	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	0.6904	3.2	4.2
251	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	0.4623	2.2	2.8
252	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.2521	1.8	1.8
253	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC.	0.7394	3.7	4.7
254	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC.	0.4440	2.6	3.1
255	08	MED	*FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.2937	2.9	2.9
256	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	0.8069	3.8	5.1
257	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.8994	2.1	2.7
258	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7101	1.6	1.8
259	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9155	1.7	2.7
260	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.6827	1.2	1.4
261	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	0.9817	1.6	2.2
262	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.9301	2.9	4.3
263	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.2854	9.3	12.5
264	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.1644	5.5	7.2
265	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.6039	4.2	6.8
266	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	0.8590	2.2	3.1
267	09	SURG	PERIANAL & PILONIDAL PROCEDURES	0.9394	2.5	4.2
268	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.1026	2.3	3.6
269	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7172	5.8	8.4
270	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.7693	2.4	3.4
271	09	MED	SKIN ULCERS	1.0303	5.6	7.3
272	09	MED	MAJOR SKIN DISORDERS W CC	1.0050	4.6	6.1
273	09	MED	MAJOR SKIN DISORDERS W/O CC	0.5587	3.0	3.9
274	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1927	4.8	6.8
275	09	MED	MALIGNANT BREAST DISORDERS W/O CC	0.5526	2.2	3.0
276	09	MED	NON-MALIGANT BREAST DISORDERS	0.6805	3.5	4.5
277	09	MED	CELLULITIS AGE >17 W CC	0.8593	4.7	5.8
278	09	MED	CELLULITIS AGE >17 W/O CC	0.5495	3.6	4.3

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)*—Continued

[Explanation of footnotes: * Medicare Data Have Been Supplemented by Data From 19 States for Low Volume DRGS. ** DRGS 469 and 470 Contain Cases Which Could not be Assigned to Valid DRGS. Note: Geometric Mean is Used Only to Determine Payment for Transfer Cases. Note: Arithmetic Mean is Presented for Informational Purposes only. Note: Relative Weights are Based on Medicare Patient Data and May Not be Appropriate for Other Patients.]

DRG	MDC	Type	DRG Title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
279	09	MED	*CELLULITIS AGE 0-17	0.6601	4.2	4.2
280	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.6981	3.2	4.2
281	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.4644	2.3	2.9
282	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.2553	2.2	2.2
283	09	MED	MINOR SKIN DISORDERS W CC	0.7221	3.5	4.7
284	09	MED	MINOR SKIN DISORDERS W/O CC	0.4311	2.4	3.1
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS.	2.0499	8.0	10.7
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.0937	4.5	5.9
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.8722	7.7	10.6
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.2239	4.3	5.4
289	10	SURG	PARATHYROID PROCEDURES	0.9773	1.8	2.8
290	10	SURG	THYROID PROCEDURES	0.8951	1.7	2.2
291	10	SURG	THYROGLOSSAL PROCEDURES	0.6331	1.4	1.6
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.6826	7.3	10.7
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.3164	3.4	5.1
294	10	MED	DIABETES AGE >35	0.7571	3.4	4.5
295	10	MED	DIABETES AGE 0-35	0.7928	3.0	4.0
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8471	3.9	5.1
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5043	2.7	3.4
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.5814	2.9	4.3
299	10	MED	INBORN ERRORS OF METABOLISM	0.9420	3.8	5.4
300	10	MED	ENDOCRINE DISORDERS W CC	1.0940	4.7	6.2
301	10	MED	ENDOCRINE DISORDERS W/O CC	0.6319	2.8	3.7
302	11	SURG	KIDNEY TRANSPLANT	3.3000	7.4	8.7
303	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.4282	6.7	8.3
304	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3343	6.2	8.7
305	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.2016	2.9	3.6
306	11	SURG	PROSTATECTOMY W CC	1.2709	3.6	5.5
307	11	SURG	PROSTATECTOMY W/O CC	0.6323	1.8	2.2
308	11	SURG	MINOR BLADDER PROCEDURES W CC	1.6387	4.0	6.3
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	0.8959	1.7	2.2
310	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.1270	2.9	4.3
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	0.6262	1.5	1.8
312	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.0623	3.0	4.5
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	0.6703	1.7	2.1
314	11	SURG	*URETHRAL PROCEDURES, AGE 0-17	0.4921	2.3	2.3
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.1046	3.9	7.2
316	11	MED	RENAL FAILURE	1.3284	4.9	6.6
317	11	MED	ADMIT FOR RENAL DIALYSIS	0.6629	2.0	3.1
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1868	4.4	6.1
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.6017	2.1	2.8
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.8551	4.3	5.3
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5638	3.1	3.8
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.4987	3.2	3.7
323	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.8041	2.4	3.1
324	11	MED	URINARY STONES W/O CC	0.4638	1.5	1.8
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.6517	2.9	3.8
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4446	2.2	2.7
327	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.3680	3.1	3.1
328	11	MED	URETHRAL STRICTURE AGE >17 W CC	0.7321	2.8	3.8
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	0.4904	1.7	2.2
330	11	MED	*URETHRAL STRICTURE AGE 0-17	0.3170	1.6	1.6
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0597	4.2	5.6
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.6023	2.4	3.2
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.7795	3.3	4.7
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.5207	4.0	4.8
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.1255	2.9	3.2
336	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	0.8707	2.6	3.4
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	0.6033	1.8	2.1
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.2293	3.5	5.6
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.1074	2.9	4.6

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)*—Continued

[Explanation of footnotes: * Medicare Data Have Been Supplemented by Data From 19 States for Low Volume DRGS. ** DRGS 469 and 470 Contain Cases Which Could not be Assigned to Valid DRGS. Note: Geometric Mean is Used Only to Determine Payment for Transfer Cases. Note: Arithmetic Mean is Presented for Informational Purposes only. Note: Relative Weights are Based on Medicare Patient Data and May Not be Appropriate for Other Patients.]

DRG	MDC	Type	DRG Title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
340	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.2817	2.4	2.4
341	12	SURG	PENIS PROCEDURES	1.2142	1.9	3.1
342	12	SURG	CIRCUMCISION AGE >17	0.7922	2.4	3.2
343	12	SURG	*CIRCUMCISION AGE 0-17	0.1531	1.7	1.7
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.2658	1.6	2.4
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	1.1852	2.9	4.8
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	1.0468	4.5	6.0
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5649	2.0	2.7
348	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	0.7106	3.2	4.2
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	0.3974	1.9	2.5
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.7182	3.6	4.5
351	12	MED	*STERILIZATION, MALE	0.2349	1.3	1.3
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.7283	2.9	4.0
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.8769	5.0	6.5
354	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.5499	4.8	5.8
355	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	0.9144	3.0	3.2
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	0.7657	1.9	2.2
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.3330	6.7	8.4
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.2295	3.5	4.3
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	0.8345	2.4	2.6
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	0.8851	2.3	2.8
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.1095	2.3	3.6
362	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	0.3003	1.4	1.4
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.8840	2.6	3.6
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.8391	2.7	3.9
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.9491	5.2	7.7
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2885	4.9	6.9
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.5416	2.3	3.0
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.2032	5.2	6.7
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	0.5950	2.4	3.2
370	14	SURG	CESAREAN SECTION W CC	0.9848	4.4	5.7
371	14	SURG	CESAREAN SECTION W/O CC	0.6745	3.2	3.6
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.6259	2.6	3.7
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.3934	2.0	2.3
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.7727	2.5	2.9
375	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.5733	4.4	4.4
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	0.4851	2.6	3.5
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	1.4354	3.0	4.2
378	14	MED	ECTOPIC PREGNANCY	0.8368	2.0	2.5
379	14	MED	THREATENED ABORTION	0.3916	2.1	3.0
380	14	MED	ABORTION W/O D&C	0.3631	1.6	2.0
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.5896	1.6	2.1
382	14	MED	FALSE LABOR	0.1683	1.2	1.3
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.5474	2.7	4.0
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	0.4204	1.8	2.8
385	15	MED	*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3680	1.8	1.8
386	15	MED	*EXTREME IMMATURITY	4.5111	17.9	17.9
387	15	MED	*PREMATURITY W MAJOR PROBLEMS	3.0810	13.3	13.3
388	15	MED	*PREMATURITY W/O MAJOR PROBLEMS	1.8590	8.6	8.6
389	15	MED	*FULL TERM NEONATE W MAJOR PROBLEMS	3.1648	4.7	4.7
390	15	MED	*NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1201	3.4	3.4
391	15	MED	*NORMAL NEWBORN	0.1517	3.1	3.1
392	16	SURG	SPLENECTOMY AGE >17	3.1665	6.9	9.5
393	16	SURG	*SPLENECTOMY AGE 0-17	1.3400	9.1	9.1

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)*—Continued

[Explanation of footnotes: * Medicare Data Have Been Supplemented by Data From 19 States for Low Volume DRGS. ** DRGS 469 and 470 Contain Cases Which Could not be Assigned to Valid DRGS. Note: Geometric Mean is Used Only to Determine Payment for Transfer Cases. Note: Arithmetic Mean is Presented for Informational Purposes only. Note: Relative Weights are Based on Medicare Patient Data and May Not be Appropriate for Other Patients.]

DRG	MDC	Type	DRG Title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.8110	4.3	7.1
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	0.8156	3.2	4.4
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	0.6591	2.4	3.8
397	16	MED	COAGULATION DISORDERS	1.2421	3.7	5.2
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2700	4.6	5.9
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6890	2.8	3.6
400	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6787	5.5	9.0
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.7850	8.0	11.3
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.1248	2.7	3.9
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.7709	5.7	8.0
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.8587	3.0	4.2
405	17	MED	*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.8998	4.9	4.9
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.8059	6.9	9.7
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.2905	3.3	4.1
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	2.0623	4.7	7.9
409	17	MED	RADIOTHERAPY	1.2077	4.5	6.1
410	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	1.0456	3.1	4.0
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.3898	2.2	2.9
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	0.2792	1.6	2.0
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3696	5.3	7.3
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.6931	3.0	4.0
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.6798	10.4	14.5
416	18	MED	SEPTICEMIA AGE >17	1.5985	5.6	7.5
417	18	MED	SEPTICEMIA AGE 0-17	1.1847	4.5	6.2
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0459	4.8	6.2
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.8674	3.6	4.7
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.5908	2.8	3.4
421	18	MED	VIRAL ILLNESS AGE >17	0.7062	2.9	3.8
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.4381	2.4	3.0
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.7896	5.9	8.3
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.3048	8.1	13.0
425	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION.	0.6822	2.9	3.9
426	19	MED	DEPRESSIVE NEUROSES	0.5167	3.2	4.5
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.5188	3.1	4.4
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.7408	4.4	7.4
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.8448	4.7	6.3
430	19	MED	PSYCHOSES	0.7128	5.7	8.0
431	19	MED	CHILDHOOD MENTAL DISORDERS	0.5940	4.2	5.9
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.6348	2.9	4.6
433	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.2755	2.2	3.0
434	20	MED	NO LONGER VALID	0.0000	0.0	0.0
435	20	MED	NO LONGER VALID	0.0000	0.0	0.0
436	20	MED	NO LONGER VALID	0.0000	0.0	0.0
437	20	MED	NO LONGER VALID	0.0000	0.0	0.0
438	20		NO LONGER VALID	0.0000	0.0	0.0
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.6965	5.4	8.5
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.9156	5.7	9.1
441	21	SURG	HAND PROCEDURES FOR INJURIES	0.9314	2.1	3.1
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.4136	5.6	8.6
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.0679	2.6	3.5
444	21	MED	TRAUMATIC INJURY AGE >17 W CC	0.7614	3.2	4.3
445	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	0.4881	2.3	2.9
446	21	MED	*TRAUMATIC INJURY AGE 0-17	0.2945	2.4	2.4
447	21	MED	ALLERGIC REACTIONS AGE >17	0.4992	1.8	2.4
448	21	MED	*ALLERGIC REACTIONS AGE 0-17	0.0969	2.9	2.9
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.8267	2.6	3.7
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.4260	1.6	2.0
451	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.2615	2.1	2.1
452	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0433	3.5	5.0

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)*—Continued

[Explanation of footnotes: *Medicare Data Have Been Supplemented by Data From 19 States for Low Volume DRGS. **DRGS 469 and 470 Contain Cases Which Could not be Assigned to Valid DRGS. Note: Geometric Mean is Used Only to Determine Payment for Transfer Cases. Note: Arithmetic Mean is Presented for Informational Purposes only. Note: Relative Weights are Based on Medicare Patient Data and May Not be Appropriate for Other Patients.]

DRG	MDC	Type	DRG Title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	0.5146	2.1	2.8
454	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.8281	3.0	4.3
455	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.4582	1.8	2.4
456	22		NO LONGER VALID	0.0000	0.0	0.0
457	22	MED	NO LONGER VALID	0.0000	0.0	0.0
458	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
459	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
460	22	MED	NO LONGER VALID	0.0000	0.0	0.0
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.2060	2.2	4.1
462	23	MED	REHABILITATION	1.1298	9.3	11.5
463	23	MED	SIGNS & SYMPTOMS W CC	0.6957	3.2	4.2
464	23	MED	SIGNS & SYMPTOMS W/O CC	0.4959	2.4	3.0
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	0.6786	1.8	2.9
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	0.7500	2.2	4.1
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.6012	2.1	8.5
468	.....		EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.7267	9.2	13.0
469	.....		**PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470	.....		**UNGROUPABLE	0.0000	0.0	0.0
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	3.1053	4.8	5.5
472	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
473	17	SURG	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.5411	7.3	12.6
474	04	SURG	NO LONGER VALID	0.0000	0.0	0.0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.6632	8.0	11.4
476	.....	SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2592	8.0	11.3
477	.....	SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.8618	5.3	8.2
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.3725	4.9	7.4
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4321	2.5	3.3
480	PRE	SURG	LIVER TRANSPLANT	10.3805	15.7	21.8
481	PRE	SURG	BONE MARROW TRANSPLANT	7.1307	19.3	22.1
482	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	3.5614	9.7	12.6
483	PRE	SURG	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE,MOUTH & NECK DX.	17.0510	34.8	42.2
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.5768	8.8	13.1
485	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA.	3.0493	7.7	9.5
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.8153	8.3	12.3
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	2.0055	5.5	7.8
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.6556	11.4	16.9
489	25	MED	HIV W MAJOR RELATED CONDITION	1.7997	6.0	8.6
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0261	3.7	5.3
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.7037	2.9	3.5
492	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	3.9528	9.2	15.0
493	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8152	4.3	5.9
494	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0107	1.9	2.5
495	PRE	SURG	LUNG TRANSPLANT	9.2016	14.4	17.3
496	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.7988	7.1	9.5
497	08	SURG	SPINAL FUSION EXCEPT CERVICAL W CC	3.3938	5.4	6.5
498	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O CC	2.4738	3.7	4.1
499	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4399	3.3	4.6
500	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	0.9489	2.0	2.5
501	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.5922	8.4	10.6
502	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.5368	5.2	6.4
503	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2128	2.9	3.9
504	22	SURG	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	14.6542	26.7	34.9
505	22	MED	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	2.0178	2.2	3.7
506	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.6725	12.7	17.3

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)*—Continued

[Explanation of footnotes: *Medicare Data Have Been Supplemented by Data From 19 States for Low Volume DRGS. **DRGS 469 and 470 Contain Cases Which Could not be Assigned to Valid DRGS. Note: Geometric Mean is Used Only to Determine Payment for Transfer Cases. Note: Arithmetic Mean is Presented for Informational Purposes only. Note: Relative Weights are Based on Medicare Patient Data and May Not be Appropriate for Other Patients.]

DRG	MDC	Type	DRG Title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
507	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.7246	6.5	9.0
508	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.4330	5.8	8.4
509	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	0.9691	4.1	5.7
510	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.2301	4.6	6.7
511	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.7006	3.0	4.4
512	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.8613	11.9	14.5
513	PRE	SURG	PANCREAS TRANSPLANT	6.3271	9.4	10.8
514	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W CARDIAC CATH	6.3376	5.0	7.3
515	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.0562	3.3	5.5
516	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W AMI	2.7273	3.7	4.8
517	05	SURG	PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	2.1789	1.9	2.6
518	05	SURG	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	1.7297	2.3	3.4
519	08	SURG	CERVICAL SPINAL FUSION W CC	2.3551	3.2	5.2
520	08	SURG	CERVICAL SPINAL FUSION W/O CC	1.5389	1.7	2.1
521	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.7300	4.3	5.8
522	20	MED	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC.	0.5818	7.5	9.5
523	20	MED	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC.	0.3999	3.3	4.1
524	01	MED	TRANSIENT ISCHEMIA	0.7238	2.7	3.4
525	05	SURG	HEART ASSIST SYSTEM IMPLANT	11.6479	9.4	16.6
526	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG ELUTING STENT W AMI.	3.1176	3.7	4.7
527	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG ELUTING STENT W/O AMI.	2.5342	1.9	2.6

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
040.82	Toxic shock syndrome	Y	18	423
066.4	West Nile fever	N	18	421, 422
277.02	Cystic fibrosis with pulmonary manifestations	Y	4	79, 80, 81
277.03	Cystic fibrosis with gastrointestinal manifestations	Y	6	188, 189, 190
277.09	Cystic fibrosis with other manifestations	Y	10	296, 297, 298
357.81	Chronic inflammatory demyelinating polyneuritis	N	1	18, 19
357.82	Critical illness polyneuropathy	N	1	18, 19
357.89	Other inflammatory and toxic neuropathy	N	1	18, 19
359.81	Critical illness myopathy	N	1	34, 35
359.89	Other myopathies	N	1	34, 35
365.83	Aqueous misdirection	N	2	46, 47, 48
414.06	Coronary atherosclerosis of coronary artery of transplanted heart	N	5	132, 133
414.12	Dissection of coronary artery	N	5	121, 144, 145
428.20	Unspecified systolic heart failure	Y	5	115, 121, 124, 127
428.21	Acute systolic heart failure	Y	5	115, 121, 124, 127
428.22	Chronic systolic heart failure	Y	5	115, 121, 124, 127
428.23	Acute on chronic systolic heart failure	Y	5	115, 121, 124, 127
428.30	Unspecified diastolic heart failure	Y	5	115, 121, 124, 127
428.31	Acute diastolic heart failure	Y	5	115, 121, 124, 127
428.32	Chronic diastolic heart failure	Y	5	115, 121, 124, 127
428.33	Acute on chronic diastolic heart failure	Y	5	115, 121, 124, 127
428.40	Unspecified combined systolic and diastolic heart failure	Y	5	115, 121, 124, 127
428.41	Acute combined systolic and diastolic heart failure	Y	5	115, 121, 124, 127
428.42	Chronic combined systolic and diastolic heart failure	Y	5	115, 121, 124, 127
428.43	Acute on chronic combined systolic and diastolic heart failure	Y	5	115, 121, 124, 127
438.6	Alterations of sensations	N	1	12
438.7	Disturbances of vision	N	1	12
438.83	Facial weakness	N	1	12
438.84	Ataxia	N	1	12
438.85	Vertigo	N	1	12
443.21	Dissection of carotid artery	N	5	130, 131

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
443.22	Dissection of iliac artery	N	5	130, 131
443.23	Dissection of renal artery	N	11	331, 332, 333
443.24	Dissection of vertebral artery	N	5	130, 131
443.29	Dissection of other artery	N	5	130, 131
445.01	Atheroembolism, upper extremity	Y	5	130, 131
445.02	Atheroembolism, lower extremity	Y	5	130, 131
445.81	Atheroembolism, kidney	Y	11	331, 332, 333
445.89	Atheroembolism, other site	Y	5	130, 131
454.8	Varicose veins of the lower extremities, with other complications	N	5	130, 131
459.10	Postphlebetic syndrome without complications	N	5	130, 131
459.11	Postphlebetic syndrome with ulcer	N	5	130, 131
459.12	Postphlebetic syndrome with inflammation	N	5	130, 131
459.13	Postphlebetic syndrome with ulcer and inflammation	N	5	130, 131
459.19	Postphlebetic syndrome with other complication	N	5	130, 131
459.30	Chronic venous hypertension without complications	N	5	130, 131
459.31	Chronic venous hypertension with ulcer	N	5	130, 131
459.32	Chronic venous hypertension with inflammation	N	5	130, 131
459.33	Chronic venous hypertension with ulcer and inflammation	N	5	130, 131
459.39	Chronic venous hypertension with other complication	N	5	130, 131
537.84	Dielulafoy lesion (hemorrhagic) of stomach and duodenum	Y	6	174, 175
569.86	Dieulafoy lesion (hemorrhagic) of intestine	Y	6	188, 189, 190
633.00	Abdominal pregnancy without intrauterine pregnancy	N	14	378
633.01	Abdominal pregnancy with intrauterine pregnancy	N	14	378
633.10	Tubal pregnancy without intrauterine pregnancy	N	14	378
633.11	Tubal pregnancy with intrauterine pregnancy	N	14	378
633.20	Ovarian pregnancy without intrauterine pregnancy	N	14	378
633.21	Ovarian pregnancy with intrauterine pregnancy	N	14	378
633.80	Other ectopic pregnancy without intrauterine pregnancy	N	14	378
633.81	Other ectopic pregnancy with intrauterine pregnancy	N	14	378
633.90	Unspecified ectopic pregnancy without intrauterine pregnancy	N	14	378
633.91	Unspecified ectopic pregnancy with intrauterine pregnancy	N	14	378
747.83	Persistent fetal circulation	N	15	387, 389
765.20	Unspecified weeks of gestation	N	15	391
765.21	Less than 24 completed weeks of gestation	N	15	386
765.22	24 completed weeks of gestation	N	15	386
765.23	25-26 completed weeks of gestation	N	15	386
765.24	27-28 completed weeks of gestation	N	15	387, 388
765.25	29-30 completed weeks of gestation	N	15	387, 388
765.26	31-32 completed weeks of gestation	N	15	387, 388
765.27	33-34 completed weeks of gestation	N	15	387, 388
765.28	35-36 completed weeks of gestation	N	15	387, 388
765.29	37 or more completed weeks of gestation	N	15	391
770.81	Primary apnea of newborn	N	15	390
770.82	Other apnea of newborn	N	15	390
770.83	Cyanotic attacks of newborn	N	15	390
770.84	Respiratory failure of newborn	Y	15	387, 389
770.89	Other respiratory problems after birth	N	15	390
771.81	Septicemia [sepsis] of newborn	Y	15	387, 389
771.82	Urinary tract infection of newborn	N	15	387, 389
771.83	Bacteremia of newborn	Y	15	387, 389
771.89	Other infections specific to the perinatal period	N	15	387, 389
779.81	Neonatal bradycardia	N	15	390
779.82	Neonatal tachycardia	N	15	390
779.89	Other specified conditions originating in the perinatal period	N	15	390
780.91	Fussy infant (baby)	N	23	463,464
780.92	Excessive crying of infant (baby)	N	23	463,464
780.99	Other general symptoms	N	23	463,464
781.93	Ocular torticollis	N	8	243
795.00	Nonspecific abnormal Papanicolaou smear of cervix, unspecified	N	13	358, 359, 369
795.01	Atypical squamous cell changes of undetermined significance favor benign (ASCUS favor benign).	N	13	358, 359, 369
795.02	Atypical squamous cell changes of undetermined significance favor dysplasia (ASCUS favor dysplasia).	N	13	358, 359, 369
795.09	Other nonspecific abnormal Papanicolaou smear of cervix	N	13	358, 359, 369
795.31	Nonspecific positive findings for anthrax	N	18	423
795.39	Other nonspecific positive culture findings	N	18	423
813.45	Torus fracture of radius	N	8	250, 251, 252
			24	487
823.40	Torus fracture, tibia alone	N	8	253, 254, 255
			24	487
823.41	Torus fracture, fibula alone	N	8	253, 254, 255
			24	487

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
823.42	Torus fracture, fibula with tibia	N	8	253, 254, 255
			24	487
995.90	Systemic inflammatory response syndrome, unspecified	Y	18	416, 417
995.91	Systemic inflammatory response syndrome due to infectious process without organ dysfunction.	Y	18	416, 417
995.92	Systemic inflammatory response syndrome due to infectious process with organ dysfunction.	Y	18	416, 417
995.93	Systemic inflammatory response syndrome due to non-infectious process without organ dysfunction.	Y	18	416, 417
995.94	Systemic inflammatory response syndrome due to non-infectious process with organ dysfunction.	Y	18	416, 417
998.31	Disruption of internal operation wound	Y	21	452, 453
998.32	Disruption of external operation wound	Y	21	452, 453
V01.81	Contact with or exposure to communicable diseases, anthrax	N	15	391 [1]
			23	467
V01.89	Contact with or exposure to communicable diseases, other communicable diseases.	N	15	391 [1]
			23	467
V13.21	Personal history of pre-term labor	N	23	467
V13.29	Personal history of other genital system and obstetric disorders	N	23	467
V23.41	Pregnancy with history of pre-term labor	N	14	469
V23.49	Pregnancy with other poor obstetric history	N	14	469
V46.2	Other dependence on machines, supplemental oxygen	N	23	467
V54.10	Aftercare for healing traumatic fracture of arm, unspecified	N	8	249
V54.11	Aftercare for healing traumatic fracture of upper arm	N	8	249
V54.12	Aftercare for healing traumatic fracture of lower arm	N	8	249
V54.13	Aftercare for healing traumatic fracture of hip	N	8	249
V54.14	Aftercare for healing traumatic fracture of leg, unspecified	N	8	249
V54.15	Aftercare for healing traumatic fracture of upper leg	N	8	249
V54.16	Aftercare for healing traumatic fracture of lower leg	N	8	249
V54.17	Aftercare for healing traumatic fracture of vertebrae	N	8	249
V54.19	Aftercare for healing traumatic fracture of other bone	N	8	249
V54.20	Aftercare for healing pathologic fracture of arm, unspecified	N	8	249
V54.21	Aftercare for healing pathologic fracture of upper arm	N	8	249
V54.22	Aftercare for healing pathologic fracture of lower arm	N	8	249
V54.23	Aftercare for healing pathologic fracture of hip	N	8	249
V54.24	Aftercare for healing pathologic fracture of leg, unspecified	N	8	249
V54.25	Aftercare for healing pathologic fracture of upper leg	N	8	249
V54.26	Aftercare for healing pathologic fracture of lower leg	N	8	249
V54.27	Aftercare for healing pathologic fracture of vertebrae	N	8	249
V54.29	Aftercare for healing pathologic fracture of other bone	N	8	249
V54.81	Aftercare following joint replacement	N	8	249
V54.89	Other orthopedic aftercare	N	8	249
V58.42	Aftercare following surgery for neoplasm	N	23	465, 466
V58.43	Aftercare following surgery for injury and trauma	N	23	465, 466
V58.71	Aftercare following surgery of the sense organs, NEC	N	23	465, 466
V58.72	Aftercare following surgery of the nervous system, NEC	N	23	465, 466
V58.73	Aftercare following surgery of the circulatory system, NEC	N	23	465, 466
V58.74	Aftercare following surgery of the respiratory system, NEC	N	23	465, 466
V58.75	Aftercare following surgery of the teeth, oral cavity and digestive system, NEC	N	23	465, 466
V58.76	Aftercare following surgery of the genitourinary system, NEC	N	23	465, 466
V58.77	Aftercare following surgery of the skin and subcutaneous tissue, NEC	N	23	465, 466
V58.78	Aftercare following surgery of the musculoskeletal system, NEC	N	23	465, 466
V71.82	Observation and evaluation for suspected exposure to anthrax	N	23	467
V71.83	Observation and evaluation for suspected exposure to other biological agent	N	23	467
V83.81	Cystic fibrosis gene carrier	N	23	467
V83.89	Other genetic carrier status	N	23	467

[1] Classified as an ''only secondary diagnosis'' in this DRG.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
00.01	Therapeutic ultrasound of vessels of head and neck	N		
00.02	Therapeutic ultrasound of heart	N		
00.03	Therapeutic ultrasound of peripheral vascular vessels	N		
00.09	Other therapeutic ultrasound	N		
00.10	Implantation of chemotherapeutic agent	N		
00.11	Infusion of drotrecogin alfa (activated)	N		
00.12	Administration of inhaled nitric oxide	N		

TABLE 6B.—NEW PROCEDURE CODES—Continued

Procedure code	Description	OR	MDC	DRG
00.13	Injection or infusion of nesiritide	N		
00.14	Injection or infusion of oxazolidinone class of antibiotics	N		
00.50	Implantation of cardiac resynchronization pacemaker without mention of defibrillation, total system [CRT-P].	Y	5	115 [1], 116 [1]
00.51	Implantation of cardiac resynchronization defibrillator, total system [CRT-D]	Y	5	514 [1], 515 [1]
00.52	Implantation or replacement of transvenous lead (electrode) into left ventricular coronary venous system.	Y	5	115 [2], 116 [3], 514 [4], 515 [4]
00.53	Implantation or replacement of cardiac resynchronization pacemaker pulse generator only [CRT-P].	Y	5	115 [2], 116 [3], 118
00.54	Implantation or replacement of cardiac resynchronization defibrillator pulse generator only [CRT-D].	Y	5	115 [1], 514 [4], 515 [4]
00.55	Insertion of drug-eluting non-coronary artery stent(s)	N		
36.07	Insertion of drug-eluting coronary artery stents(s)	N *	5	526, 527
39.72	Endovascular repair or occlusion of head and neck vessels	Y	1	1,2,3
			5	110, 111
			11	315
			21	442, 443
			24	486
49.75	Implantation or revision of artificial anal sphincter	Y	6	157, 158
			9	267
			21	442, 443
			24	486
49.76	Removal of artificial anal sphincter	Y	6	157, 158
			9	267
			21	442, 443
			24	486
81.61	360 degree spinal fusion, single incision approach	Y	1	4
			8	496
			21	442, 443
			24	486
84.51	Insertion of interbody spinal fusion device	N		
84.52	Insertion of recombinant bone morphogenetic protein	N		
88.96	Other intraoperative magnetic resonance imaging	N		
89.60 [5]	Continuous intra-arterial blood gas monitoring	N		
99.76	Extracorporeal immunoadsorption	N		
99.77	Application or administration of an adhesion barrier substance	N		

* Nonoperating room procedure, but affects DRG.
[1] Classified under ''operating room procedures''.
[2] Classified under ''operating room procedure'' and under ''as any of the following procedure combinations'' as 00.52 and 00.53.
[3] Classified under ''any of the following procedure combinations'' as 00.52 and 00.53.
[4] Classified under ''any of the following procedure combinations'' as 00.52 and 00.54.
[5] This code was discussed at the April 18, 2002 meeting of the ICD-9-CM Coordination and Maintenance Committee and included in the final addendum for ICD-9-CM.

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
357.8	Other inflammatory and toxic neuropathy	N	1	18, 19
359.8	Other myopathies	N	1	34, 35
459.1	Postphlebetic syndrome	N	5	130, 131
633.0	Abdominal pregnancy	N	14	378
633.1	Tubal pregnancy	N	14	378
633.2	Ovarian pregnancy	N	14	378
633.8	Other ectopic pregnancy	N	14	378
633.9	Unspecified ectopic pregnancy	N	14	378
770.8	Other respiratory problems after birth	N	15	387, 389
771.8	Other infections specific to the perinatal period	Y	15	387, 389
779.8	Other specified conditions originating in the perinatal period	N	15	390
780.9	Other general symptoms	N	23	463, 464
795.0	Nonspecific abnormal Papanicolaou smear of cervix	N	13	358, 359, 369
795.3	Nonspecific positive culture findings	N	18	423
998.3	Disruption of operation wound	Y	21	452, 453
V01.8	Other communicable diseases	N	23	467
V13.2	Other genital system and obstetric disorders	N	23	467
V23.4	Pregnancy with other poor obstetric history	N	14	469
V54.8	Other orthopedic aftercare	N	8	249

TABLE 6D.—INVALID PROCEDURE CODES

Note: There are no invalid procedure codes for FY 2003.

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
402.00	Hypertensive heart disease, malignant, without heart failure	Y	5	134
402.01	Hypertensive heart disease, malignant, with heart failure	Y	5	115, 121, 124, 127
402.10	Hypertensive heart disease, benign, without heart failure	N	5	134
402.11	Hypertensive heart disease, benign, with heart failure	Y	5	115, 121, 124, 127
402.90	Hypertensive heart disease, unspecified, without heart failure	N	5	134
402.91	Hypertensive heart disease, unspecified, with heart failure	Y	5	115, 121, 124, 127
404.00	Hypertensive heart and renal disease, malignant, without mention of heart failure or renal failure.	Y	5	134
404.01	Hypertensive heart and renal disease, malignant, with heart failure	Y	5	115, 121, 124, 127
404.03	Hypertensive heart and renal disease, malignant, with heart failure and renal failure.	Y	5	115, 121, 124, 127
404.10	Hypertensive heart and renal disease, benign, without mention of heart failure or renal failure.	N	5	134
404.11	Hypertensive heart and renal disease, benign, with heart failure	Y	5	115, 121, 124, 127
404.13	Hypertensive heart and renal disease, benign, with heart failure and renal failure.	Y	5	115, 121, 124, 127
404.90	Hypertensive heart and renal disease, unspecified, without mention of heart failure or renal failure.	N	5	134
404.91	Hypertensive heart and renal disease, unspecified, with heart failure	Y	5	115, 121, 124, 127
404.93	Hypertensive heart and renal disease, unspecified, with heart failure and renal failure.	Y	5	115, 121, 124, 127
414.10	Aneurysm of heart	N	5	121, 144, 145
414.11	Aneurysm of coronary vessels	N	5	121, 144, 145
414.19	Other aneurysm of heart	N	5	121, 144, 145
428.0	Congestive heart failure, unspecified	Y	5	115, 121, 124, 127
454.9	Asymptomatic varicose veins	N	5	130, 131
627.2	Symptomatic menopausal or female climacteric states	N	13	358, 359, 369
627.4	Symptomatic states associated with artificial menopause	N	13	358, 359, 369
V49.81	Asymptomatic postmenopausal status (age-related) (natural)	N	23	467

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	OR	MDC	DRG
02.41 [1]	Irrigation and exploration of ventricular shunt	N		
36.06	Insertion of non-drug-eluting coronary artery stents(s)	N*	5	517
39.79	Other endovascular repair of aneurysm of other vessels	Y	1	1, 2, 3
			5	110, 111
			11	315
			21	442, 443
			24	486
39.90	Insertion of non-drug-eluting, noncoronary artery stents(s)	N		

* Nonoperating room procedure, but affects DRG.

[1] This code title revision was discussed at the April 18, 2002 meeting of the ICD-9-CM Coordination and Maintenance Committee and included in the final addendum for ICD-9-CM.

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST

[CCs that are added to the list are in Table 6G-Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

*0031	99591	6829	99591	99593	44501	42821	4280
99590	99592	99590	99592	99594	44502	42822	4281
99591	99593	99591	99593	*04186	44581	42823	42820
99592	99594	99592	99594	99590	44589	42830	42821
99593	*03843	99593	*0412	99591	*25090	42831	42822
99594	99590	99594	99590	99592	44501	42832	42823
*0202	99591	*04089	99591	99593	44502	42833	42830
99590	99592	99590	99592	99594	44581	42840	42831
99591	99593	99591	99593	*04189	44589	42841	42832
99592	99594	99592	99594	99590	*25091	42842	42833
99593	*03844	99593	*0413	99591	44501	42843	42840
99594	99590	99594	99590	99592	44502	*40211	42841
*0362	99591	*04100	99591	99593	44581	42820	42842
99590	99592	99590	99592	99594	44589	42821	42843
99591	99593	99591	99593	*0419	*25092	42822	4289
99592	99594	99592	99594	99590	44501	42823	5184
99593	*03849	99593	*0414	99591	44502	42830	*42821
99594	99590	99594	99590	99592	44581	42831	39891
*0380	99591	*04101	99591	99593	44589	42832	40201
99590	99592	99590	99592	99594	*25093	42833	40211
99591	99593	99591	99593	*0545	44501	42840	40291
99592	99594	99592	99594	99590	44502	42841	4280
99593	*0388	99593	*0415	99591	44581	42842	4281
99594	99590	99594	99590	99592	44589	42843	42820
*03810	99591	*04102	99591	99593	*2515	*40291	42821
99590	99592	99590	99592	99594	53784	42820	42822
99591	99593	99591	99593	*1398	56986	42821	42823
99592	99594	99592	99594	99590	*27700	42822	42830
99593	*0389	99593	*0416	99591	27702	42823	42831
99594	99590	99594	99590	99592	27703	42830	42832
*03811	99591	*04103	99591	99593	27709	42831	42833
99590	99592	99590	99592	99594	*27701	42832	42840
99591	99593	99591	99593	*25070	27702	42833	42841
99592	99594	99592	99594	44501	27703	42840	42842
99593	*04082	99593	*0417	44502	27709	42841	42843
99594	0380	99594	99590	44581	*27702	42842	4289
*03819	03810	*04104	99591	44589	27700	42843	5184
99590	03811	99590	99592	*25071	27701	*4280	*42822
99591	03819	99591	99593	44501	27702	42820	39891
99592	0382	99592	99594	44502	27703	42821	40201
99593	0383	99593	*04181	44581	27709	42822	40211
99594	03840	99594	99590	44589	*27703	42823	40291
*0382	03841	*04105	99591	*25072	27700	42830	4280
99590	03842	99590	99592	44501	27701	42831	4281
99591	03843	99591	99593	44502	27702	42832	42820
99592	03844	99592	99594	44581	27703	42833	42821
99593	03849	99593	*04182	44589	27709	42840	42822
99594	0388	99594	99590	*25073	*27709	42841	42823
*0383	0389	*04109	99591	44501	27700	42842	42830
99590	04082	99590	99592	44502	27701	42843	42831
99591	6800	99591	99593	44581	27702	*4281	42832
99592	6801	99592	99594	44589	27703	42820	42833
99593	6802	99593	*04183	*25080	27709	42821	42840
99594	6803	99594	99590	44501	*39891	42822	42841
*03840	6804	*04110	99591	44502	42820	42823	42842
99590	6805	99590	99592	44581	42821	42830	42843
99591	6806	99591	99593	44589	42822	42831	4289
99592	6807	99592	99594	*25081	42823	42832	5184
99593	6808	99593	*04184	44501	42830	42833	*42823
99594	6809	99594	99590	44502	42831	42840	39891
*03841	6820	*04111	99591	44581	42832	42841	40201
99590	6821	99590	99592	44589	42833	42842	40211
99591	6822	99591	99593	*25082	42840	42843	40291
99592	6823	99592	99594	44501	42841	*42820	4280
99593	6825	99593	*04185	44502	42842	39891	4281
99594	6826	99594	99590	44581	42843	40201	42820
*03842	6827	*04119	99591	44589	*40201	40211	42821
99590	6828	99590	99592	*25083	42820	40291	42822
42823	5184	42822	42831	56986	*53270	53784	*56202
42830	*42833	42823	42832	*53140	53784	56986	53784
42831	39891	42830	42833	53784	56986	*53411	56986
42832	40201	42831	42840	56986	*53271	53784	*56203

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are in Table 6G-Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

42833	40211	42832	42841	*53141	53784	56986	53784
42840	40291	42833	42842	53784	56986	*53420	56986
42841	4280	42840	42843	56986	*53290	53784	*56212
42842	4281	42841	44501	*53150	53784	56986	53784
42843	42820	42842	44502	53784	56986	*53421	56986
4289	42821	42843	44581	56986	*53291	53784	*56213
5184	42822	4289	44589	*53151	53784	56986	53784
*42830	42823	5184	*4599	53784	56986	*53430	56986
39891	42830	*42843	42820	56986	*53300	53784	*5693
40201	42831	39891	42821	*53160	53784	56986	53784
40211	42832	40201	42822	53784	56986	*53431	56986
40291	42833	40211	42823	56986	*53301	53784	*56985
4280	42840	40291	42830	*53161	53784	56986	53784
4281	42841	4280	42831	53784	56986	*53440	56986
42820	42842	4281	42832	56986	*53310	53784	*56986
42821	42843	42820	42833	*53170	53784	56986	56986
42822	4289	42821	42840	53784	56986	*53441	*5780
42823	5184	42822	42841	56986	*53311	53784	53784
42830	*42840	42823	42842	*53171	53784	56986	56986
42831	39891	42830	42843	53784	56986	*53450	*5781
42832	40201	42831	44501	56986	*53320	53784	53784
42833	40211	42832	44502	*53190	53784	56986	56986
42840	40291	42833	44581	53784	56986	*53451	*5789
42841	4280	42840	44589	56986	*53321	53784	53784
42842	4281	42841	*5184	*53191	53784	56986	56986
42843	42820	42842	42820	53784	56986	*53460	*74783
4289	42821	42843	42821	56986	*53330	53784	42971
5184	42822	4289	42822	*53200	53784	56986	42979
*42831	42823	5184	42823	53784	56986	*53461	7450
39891	42830	*4289	42830	56986	*53331	53784	74510
40201	42831	42820	42831	*53201	53784	56986	74511
40211	42832	42821	42832	53784	56986	*53470	74512
40291	42833	42822	42833	56986	*53340	53784	74519
4280	42840	42823	42840	*53210	53784	56986	7452
4281	42841	42830	42841	53784	56986	*53471	7453
42820	42842	42831	42842	56986	*53341	53784	7454
42821	42843	42832	42843	*53211	53784	56986	74560
42822	4289	42833	*5302	53784	56986	*53490	74569
42823	5184	42840	53784	56986	*53350	53784	7457
42830	*42841	42841	56986	*53220	53784	56986	74601
42831	39891	42842	*5307	53784	56986	*53491	74602
42832	40201	42843	53784	56986	*53351	53784	7461
42833	40211	*44489	56986	*53221	53784	56986	7462
42840	40291	44501	*53082	53784	56986	*53501	7463
42841	4280	44502	53784	56986	*53360	53784	7464
42842	4281	44581	56986	*53230	53784	56986	7465
42843	42820	44589	*53100	53784	56986	*53511	7466
4289	42821	*4449	53784	56986	*53361	53784	7467
5184	42822	44501	56986	*53231	53784	56986	74681
*42832	42823	44502	*53101	53784	56986	*53521	74682
39891	42830	44581	53784	56986	*53370	53784	74683
40201	42831	44589	56986	*53240	53784	56986	74684
40211	42832	*44501	*53110	53784	56986	*53531	74686
40291	42833	44501	53784	56986	*53371	53784	74711
4280	42840	*44502	56986	*53241	53784	56986	74722
4281	42841	44502	*53111	53784	56986	*53541	*76520
42820	42842	*44581	53784	56986	*53390	53784	76501
42821	42843	44581	56986	*53250	53784	56986	76502
42822	4289	*44589	*53120	53784	56986	*53551	76503
42823	5184	44589	53784	56986	*53391	53784	76504
42830	*42842	*4560	56986	*53251	53784	56986	76505
42831	39891	53784	*53121	53784	56986	*53561	76506
42832	40201	56986	53784	56986	*53400	53784	76507
42833	40211	*45989	56986	*53260	53784	56986	76508
42840	40291	42820	*53130	53784	56986	*53783	*76521
42841	4280	42821	53784	56986	*53401	53784	76501
42842	4281	42822	56986	*53261	53784	56986	76502
42843	42820	42823	*53131	53784	56986	*53784	76503
4289	42821	42830	53784	56986	*53410	53784	76504
76505	76506	769	76508	7703	7713	78039	03811
76506	76507	7700	7670	7704	77181	7817	03819
76507	76508	7701	7685	7705	77183	7854	0382

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are in Table 6G-Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

76508	*7685	7702	769	7707	77210	78550	0383
*76522	77084	7703	7700	77084	77211	78551	03840
76501	*7686	7704	7701	7710	77212	78559	03841
76502	77084	7705	7702	7711	77213	7863	03842
76503	*7689	7707	7703	7713	77214	78820	03843
76504	77084	77084	7704	77181	7722	78829	03844
76505	*769	*7709	7705	77183	7724	7895	03849
76506	77084	77084	7707	77210	7725	7907	0388
76507	*7700	*7714	77084	77211	7730	7911	0389
76508	77084	77181	7710	77212	7731	7913	0545
*76523	*7701	77183	7711	77213	7732	7991	99590
76501	77084	*7715	7713	77214	7733	7994	99591
76502	*7702	77181	77181	7722	7734	*78099	99592
76503	77084	77183	77183	7724	7740	04082	99593
76504	*7703	*7716	77210	7725	7741	44024	99594
76505	77084	77181	77211	7730	7742	78001	*99592
76506	*7704	77183	77212	7731	77430	78003	0362
76507	77084	*7717	77213	7732	77431	7801	0380
76508	*7705	77181	77214	7733	77439	78031	03810
*76524	77084	77183	7722	7734	7744	78039	03811
76501	*7706	*77181	7724	7740	7745	7817	03819
76502	77084	77181	7725	7741	7747	7854	0382
76503	*7707	77183	7730	7742	7751	78550	0383
76504	77084	*77182	7731	77430	7752	78551	03840
76505	*77081	77181	7732	77431	7753	78559	03841
76506	7685	77183	7733	77439	7754	7863	03842
76507	769	*77183	7734	7744	7755	78820	03843
76508	7700	77181	7740	7745	7756	78829	03844
*76525	7701	77183	7741	7747	7757	7895	03849
76501	7702	*77189	7742	7751	7760	7907	0388
76502	7703	77181	77430	7752	7761	7911	0389
76503	7704	77183	77431	7753	7762	7913	0545
76504	7705	*7760	77439	7754	7763	7991	99590
76505	7707	77181	7744	7755	7771	7994	99591
76506	77084	77183	7745	7756	7772	*78550	99592
76507	*77082	*7761	7747	7757	7775	04082	99593
76508	7685	77181	7751	7760	7776	*78551	99594
*76526	769	77183	7752	7761	7780	04082	*99593
76501	7700	*7762	7753	7762	7790	*78559	0362
76502	7701	77181	7754	7763	7791	04082	0380
76503	7702	77183	7755	7771	7797	*7859	03810
76504	7703	*7763	7756	7772	*78091	04082	03811
76505	7704	77181	7757	7775	04082	*7998	03819
76506	7705	77183	7760	7776	44024	04082	0382
76507	7707	*7764	7761	7780	78001	*99590	0383
76508	77084	77181	7762	7790	78003	0362	03840
*76527	*77083	77183	7763	7791	7801	0380	03841
76501	7685	*7765	7771	7797	78031	03810	03842
76502	769	77181	7772	*77989	78039	03811	03843
76503	7700	77183	7775	76501	7817	03819	03844
76504	7701	*7766	7776	76502	7854	0382	03849
76505	7702	77181	7780	76503	78550	0383	0388
76506	7703	77183	7790	76504	78551	03840	0389
76507	7704	*7767	7791	76505	78559	03841	0545
76508	7705	77181	7797	76506	7863	03842	99590
*76528	7707	77183	*77982	76507	78820	03843	99591
76501	77084	*7768	76501	76508	78829	03844	99592
76502	*77084	77181	76502	7670	7895	03849	99593
76503	7685	77183	76503	7685	7907	0388	99594
76504	769	*7769	76504	769	7911	0389	*99594
76505	7700	77181	76505	7700	7913	0545	0362
76506	7701	77183	76506	7701	7991	99590	0380
76507	7702	*77981	76507	7702	7994	99591	03810
76508	7703	76501	76508	7703	*78092	99592	03811
*76529	7704	76502	7670	7704	04082	99593	03819
76501	7705	76503	7685	7705	44024	99594	0382
76502	7707	76504	769	7707	78001	*99591	0383
76503	77084	76505	7700	77084	78003	0362	03840
76504	*77089	76506	7701	7710	7801	0380	03841
76505	7685	76507	7702	7711	78031	03810	03842
03843	99591						
03844	99592						

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are in Table 6G-Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

03849	99593
0388	99594
0389	*V096
0545	99590
99590	99591
99591	99592
99592	99593
99593	99594
99594	*V0970
*99791	99590
99831	99591
99832	99592
*99799	99593
99831	99594
99832	*V0971
*99831	99590
99831	99591
99832	99592
*99832	99593
99831	99594
99832	*V0980
*99881	99590
99831	99591
99832	99592
*99883	99593
99831	99594
99832	*V0981
*99889	99590
99831	99591
99832	99592
*9989	99593
99831	99594
99832	*V0990
*V090	99590
99590	99591
99591	99592
99592	99593
99593	99594
99594	*V0991
*V091	99590
99590	99591
99591	99592
99592	99593
99593	99594
99594	*V2341
*V092	V237
99590	V2381
99591	V2382
99592	V2383
99593	V2384
99594	V2389
*V093	V239
99590	*V2349
99591	V237
99592	V2381
99593	V2382
99594	V2383
*V094	V2384
99590	V2389
99591	V239
99592	*V462
99593	V461
99594	
*V0950	
99590	
99591	
99592	
99593	
99594	
*V0951	
99590	

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST

[CCs that are deleted from the list are in Table 6H-Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.]

*7708	7722	9983
7685	7724	*9989
769	7725	9983
7700	7730	*V234
7701	7731	V237
7702	7732	V2381
7703	7733	V2382
7704	7734	V2383
7705	7740	V2384
7707	7741	V2389
*7714	7742	V239
7718	77430	
*7715	77431	
7718	77439	
*7716	7744	
7718	7745	
*7717	7747	
7718	7751	
*7718	7752	
7718	7753	
*7760	7754	
7718	7755	
*7761	7756	
7718	7757	
*7762	7760	
7718	7761	
*7763	7762	
7718	7763	
*7764	7771	
7718	7772	
*7765	7775	
7718	7776	
*7766	7780	
7718	7790	
*7767	7791	
7718	7797	
*7768	*7809	
7718	44024	
*7769	78001	
7718	78003	
*7798	7801	
76501	78031	
76502	78039	
76503	7817	
76504	7854	
76505	78550	
76506	78551	
76507	78559	
76508	7863	
7670	78820	
7685	78829	
769	7895	
7700	7907	
7701	7911	
7702	7913	
7703	7991	
7704	7994	
7705	*99791	
7707	9983	
7710	*99799	
7711	9983	
7713	*9983	
7718	9983	
77210	*99881	
77211	9983	
77212	*99883	
77213	9983	
77214	*99889	

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)

[FY 2001 MEDPAR Update March 2002 Grouper V19.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	34885	8.9770	2	3	6	12	19
2	7211	9.9230	3	5	8	13	20
3	7	7.4290	1	1	3	4	10
4	6510	7.1900	1	2	5	9	16
5	93559	3.0670	1	1	2	3	7
6	398	2.9200	1	1	2	4	6
7	14289	9.7760	1	4	7	12	20
8	4389	2.7520	1	1	1	3	6
9	1755	6.4550	1	3	5	8	13
10	18163	6.5160	2	3	5	8	13
11	3444	4.0010	1	2	3	5	8
12	49862	5.8770	2	3	4	7	11
13	6731	5.0160	2	3	4	6	9
14	321915	5.8150	2	3	5	7	11
15	152910	3.4740	1	2	3	4	6
16	11519	6.0130	2	3	5	7	12
17	3744	3.2760	1	2	3	4	6
18	28192	5.4260	2	3	4	7	10
19	8749	3.5380	1	2	3	5	7
20	5666	10.4560	3	5	8	13	20
21	1445	6.5690	2	3	5	8	13
22	2737	5.0080	2	2	4	6	10
23	11274	4.2370	1	2	3	5	8
24	55738	4.8890	1	2	4	6	10
25	27443	3.2300	1	2	3	4	6
26	35	4.6290	1	1	2	4	6
27	3897	5.0160	1	1	3	6	11
28	12468	6.2410	1	3	5	8	13
29	4987	3.5570	1	2	3	5	7
31	3887	4.0710	1	2	3	5	8
32	1940	2.4380	1	1	2	3	5
34	21924	5.0460	1	2	4	6	9
35	6903	3.2410	1	1	3	4	6
36	2513	1.4700	1	1	1	1	2
37	1437	3.8040	1	1	2	4	8
38	93	2.4950	1	1	1	3	6
39	671	1.9400	1	1	1	2	4
40	1534	3.6140	1	1	2	5	8
42	1951	2.3660	1	1	1	3	5
43	111	3.0270	1	1	2	4	6
44	1302	5.0340	2	3	4	6	9
45	2619	3.2440	1	2	3	4	6
46	3394	4.5840	1	2	4	6	9
47	1359	3.1660	1	1	3	4	6
48	1	2.0000	2	2	2	2	2
49	2347	4.6230	1	2	3	5	9
50	2492	1.8210	1	1	1	2	3
51	254	3.1260	1	1	1	3	7
52	242	1.9130	1	1	1	2	3
53	2528	3.3780	1	1	2	4	8
54	1	4.0000	4	4	4	4	4
55	1583	3.0580	1	1	1	3	6
56	535	2.9780	1	1	2	3	6
57	696	3.7400	1	1	2	4	8
59	129	2.6740	1	1	1	3	6
60	6	3.3330	1	1	2	5	5
61	244	4.7830	1	1	3	6	10
62	3	1.6670	1	1	1	3	3
63	2951	4.4780	1	1	3	6	9
64	3168	6.5990	1	2	4	8	14
65	39160	2.7980	1	1	2	3	5
66	7719	3.1100	1	1	2	4	6
67	441	3.5940	1	2	3	4	6
68	8805	3.8300	1	2	3	5	7
69	3059	2.9940	1	2	2	4	5
70	25	3.4800	1	2	3	4	8
71	87	3.4370	1	2	3	4	6
72	934	3.5630	1	1	3	4	7
73	7115	4.3800	1	2	3	6	9
75	40165	10.0590	3	5	7	12	20

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V19.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
76	41905	11.4330	3	5	9	14	22
77	2458	4.8650	1	2	4	7	10
78	35476	6.6620	3	4	6	8	11
79	166958	8.5080	3	4	7	11	16
80	8364	5.4950	2	3	5	7	10
81	2	8.0000	3	3	13	13	13
82	63860	6.9900	2	3	6	9	14
83	6521	5.4790	2	3	4	7	10
84	1602	3.2040	1	2	3	4	6
85	21367	6.3180	2	3	5	8	12
86	2192	3.8090	1	2	3	5	8
87	59754	6.3130	1	3	5	8	12
88	398448	5.1060	2	3	4	6	9
89	504650	5.8910	2	3	5	7	11
90	47050	4.0300	2	2	3	5	7
91	55	4.0180	2	2	3	5	9
92	14891	6.3630	2	3	5	8	12
93	1721	4.1100	1	2	3	5	8
94	12688	6.3310	2	3	5	8	13
95	1704	3.7280	1	2	3	5	7
96	54007	4.5510	2	2	4	6	8
97	28779	3.5190	1	2	3	4	6
98	15	5.0000	1	2	3	4	13
99	21402	3.1730	1	1	2	4	6
100	9013	2.1320	1	1	2	3	4
101	21303	4.3870	1	2	3	6	9
102	5618	2.5720	1	1	2	3	5
103	453	51.8520	9	14	27	64	130
104	19919	14.4420	6	8	12	17	25
105	27571	9.9950	5	6	8	12	18
106	3320	11.4070	5	7	10	14	20
107	86073	10.4600	5	7	9	12	17
108	6235	10.2790	3	5	8	13	20
109	59810	7.7310	4	5	6	9	13
110	53439	9.0380	2	4	7	11	18
111	9446	4.4130	1	2	4	6	8
113	41687	12.4870	4	6	9	15	24
114	8909	8.5190	2	4	7	11	17
115	15348	8.2670	1	4	7	11	16
116	109696	4.4720	1	2	3	6	9
117	4196	4.1630	1	1	2	5	10
118	8135	2.8930	1	1	1	3	7
119	1322	5.1060	1	1	3	6	12
120	37542	8.7990	1	2	6	11	20
121	167946	6.3300	2	3	5	8	12
122	82148	3.6130	1	2	3	5	7
123	41344	4.7020	1	1	3	6	11
124	137904	4.3540	1	2	3	5	8
125	91635	2.7840	1	1	2	4	5
126	5061	11.9020	4	6	9	15	22
127	684796	5.2710	2	3	4	7	10
128	8303	5.4670	2	3	5	7	9
129	4150	2.8310	1	1	1	3	6
130	89193	5.6610	2	3	5	7	10
131	27944	4.0540	1	2	4	5	7
132	152950	2.9290	1	1	2	4	5
133	8979	2.2630	1	1	2	3	4
134	39813	3.1770	1	2	2	4	6
135	7584	4.4210	1	2	3	5	8
136	1243	2.5710	1	1	2	3	5
138	204244	3.9830	1	2	3	5	8
139	90369	2.4820	1	1	2	3	5
140	66769	2.5570	1	1	2	3	5
141	102878	3.5910	1	2	3	4	7
142	51988	2.5540	1	1	2	3	5
143	251435	2.0830	1	1	2	3	4
144	89218	5.4560	1	2	4	7	11
145	7647	2.6530	1	1	2	3	5
146	10845	10.2150	5	7	8	12	17
147	2812	6.3970	3	5	6	8	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V19.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
148	130042	12.2930	5	7	10	15	22
149	19445	6.4620	4	5	6	8	10
150	20434	11.2310	4	7	10	14	20
151	5000	5.6690	1	3	5	8	10
152	4436	8.3290	3	5	7	10	14
153	2027	5.3860	3	4	5	7	8
154	29150	13.2280	3	7	10	16	26
155	7319	3.9840	1	2	3	6	8
156	3	15.0000	11	11	13	21	21
157	8205	5.5530	1	2	4	7	11
158	4604	2.5160	1	1	2	3	5
159	17212	5.0630	1	2	4	6	10
160	12260	2.6480	1	1	2	3	5
161	11221	4.1550	1	1	3	5	9
162	7337	1.9150	1	1	1	2	4
163	3	3.0000	1	1	3	5	5
164	5142	8.2640	3	5	7	10	14
165	2201	4.6460	2	3	4	6	8
166	3935	4.8750	1	2	4	6	9
167	3833	2.5130	1	1	2	3	4
168	1409	4.8810	1	2	3	6	10
169	887	2.3160	1	1	2	3	5
170	12237	10.9980	2	4	8	14	22
171	1367	4.3180	1	2	3	6	9
172	30816	6.9650	2	3	5	9	14
173	2736	3.7380	1	1	3	5	8
174	248283	4.8070	2	3	4	6	9
175	35359	2.9190	1	2	3	4	5
176	15279	5.2510	2	3	4	6	10
177	9466	4.5110	2	2	4	6	8
178	3770	3.0770	1	2	3	4	6
179	12641	5.9620	2	3	5	7	11
180	88694	5.3720	2	3	4	7	10
181	27227	3.3760	1	2	3	4	6
182	262087	4.3630	1	2	3	5	8
183	91760	2.8830	1	1	2	4	5
184	94	2.8400	1	1	2	4	6
185	5155	4.6870	1	2	3	6	9
186	3	4.6670	2	2	3	9	9
187	698	4.1790	1	2	3	6	8
188	79822	5.5600	1	2	4	7	11
189	13196	3.0550	1	1	2	4	6
190	78	4.7690	1	2	3	5	8
191	9286	13.7420	3	6	10	17	28
192	1267	6.1130	1	3	5	8	11
193	4893	12.7480	5	7	10	16	23
194	738	6.8510	2	4	6	8	12
195	4171	10.3630	4	6	9	12	18
196	1056	5.4220	2	3	5	7	9
197	18696	8.9790	3	5	7	11	16
198	5707	4.4310	2	3	4	6	8
199	1663	9.9180	2	4	7	13	21
200	1049	10.4500	1	3	7	14	22
201	1468	14.5860	3	6	11	18	29
202	26324	6.3730	2	3	5	8	13
203	29515	6.7410	2	3	5	9	13
204	61935	5.8110	2	3	4	7	11
205	24648	6.1690	2	3	5	8	12
206	2068	3.9160	1	2	3	5	8
207	32279	5.1810	1	2	4	7	10
208	10815	2.8610	1	1	2	4	5
209	373009	4.9900	3	3	4	6	8
210	122166	6.8910	3	4	6	8	11
211	32764	4.9270	3	4	5	6	7
212	7	3.2860	1	2	2	2	4
213	9936	9.1390	2	4	7	11	18
216	6966	9.5420	2	4	7	12	19
217	17192	13.4090	3	5	9	16	28
218	23017	5.4590	2	3	4	7	10
219	21116	3.2120	1	2	3	4	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V19.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
220	1	2.0000	2	2	2	2	2
223	13773	2.8810	1	1	2	3	6
224	12585	1.8630	1	1	1	2	3
225	6183	5.0260	1	2	3	7	11
226	5746	6.6640	1	3	5	8	14
227	4975	2.6700	1	1	2	3	5
228	2509	4.0880	1	1	2	5	9
229	1194	2.2140	1	1	2	3	4
230	2432	5.0670	1	2	3	6	11
231	12627	4.8920	1	1	3	6	11
232	885	2.7380	1	1	1	3	7
233	7255	7.2080	1	3	5	9	15
234	4649	3.1560	1	1	2	4	7
235	5116	5.0300	1	2	4	6	9
236	40046	4.7420	1	3	4	6	9
237	1761	3.6000	1	2	3	4	7
238	8678	8.8670	3	4	7	11	17
239	48474	6.2820	2	3	5	8	12
240	11901	6.7280	2	3	5	8	13
241	3252	3.8840	1	2	3	5	7
242	2531	6.5780	2	3	5	8	13
243	94344	4.6810	1	2	4	6	9
244	13655	4.7310	1	2	4	6	9
245	5760	3.3620	1	2	3	4	6
246	1350	3.7580	1	2	3	5	7
247	19731	3.3700	1	1	3	4	7
248	12158	4.8690	1	2	4	6	9
249	12733	3.6440	1	1	2	4	7
250	3838	4.1640	1	2	3	5	7
251	2517	2.7750	1	1	2	4	5
253	21017	4.6730	1	3	4	6	9
254	10910	3.1320	1	2	3	4	6
255	1	2.0000	2	2	2	2	2
256	6435	5.1150	1	2	4	6	10
257	16786	2.6640	1	1	2	3	5
258	17062	1.8180	1	1	2	2	3
259	3835	2.6770	1	1	1	2	6
260	5111	1.3670	1	1	1	1	2
261	1927	2.1650	1	1	1	2	4
262	688	4.2920	1	1	3	5	10
263	24727	11.8360	3	5	8	14	23
264	4016	6.9110	2	3	5	8	14
265	4092	6.7790	1	2	4	8	14
266	2697	3.1350	1	1	2	4	6
267	272	4.2170	1	1	2	4	8
268	925	3.5950	1	1	2	4	8
269	9136	8.2100	2	3	6	10	17
270	2765	3.2770	1	1	2	4	7
271	19734	7.2900	2	4	6	9	13
272	5508	6.1320	2	3	5	7	12
273	1389	3.9270	1	2	3	5	7
274	2368	6.7490	1	3	5	8	14
275	255	3.0120	1	1	2	4	6
276	1337	4.5030	1	2	4	6	8
277	94462	5.7610	2	3	5	7	10
278	31992	4.2750	2	3	4	5	7
279	4	6.7500	3	3	6	8	10
280	17235	4.1620	1	2	3	5	8
281	7951	2.9070	1	1	2	4	5
283	5674	4.6490	1	2	4	6	9
284	1960	3.0550	1	1	2	4	6
285	6641	10.6710	3	5	8	13	20
286	2193	5.9450	2	3	4	7	11
287	6513	10.5590	3	5	8	12	20
288	3757	5.3890	2	3	4	6	8
289	6449	2.8110	1	1	1	3	6
290	9553	2.2290	1	1	1	2	4
291	78	1.6030	1	1	1	2	3
292	5462	9.9410	2	4	8	13	20
293	354	4.9320	1	2	3	7	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V19.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
294	95967	4.5380	1	2	3	6	9
295	3387	3.9770	1	2	3	5	7
296	252270	5.1150	1	2	4	6	10
297	47995	3.3570	1	2	3	4	6
298	109	4.2750	1	2	3	5	7
299	1225	5.3900	1	2	4	6	10
300	17627	6.1590	2	3	5	8	12
301	3661	3.6680	1	2	3	5	7
302	8130	8.6850	4	5	7	10	15
303	20792	8.2750	3	4	6	9	15
304	12047	8.6780	2	4	6	11	18
305	2997	3.5710	1	2	3	4	6
306	7239	5.4920	1	2	3	7	13
307	2175	2.1990	1	1	2	3	4
308	7397	6.3290	1	2	4	8	14
309	4393	2.1880	1	1	2	3	4
310	24716	4.3420	1	1	3	5	9
311	8387	1.8230	1	1	1	2	3
312	1557	4.4950	1	1	3	6	10
313	646	2.1250	1	1	1	2	4
314	1	5.0000	5	5	5	5	5
315	31462	6.8980	1	1	4	9	16
316	117216	6.6330	2	3	5	8	13
317	1913	3.0910	1	1	2	3	7
318	5785	6.0350	1	3	4	8	12
319	503	2.8330	1	1	2	3	6
320	194230	5.3020	2	3	4	7	10
321	30917	3.7520	1	2	3	5	7
322	68	3.7350	1	2	3	5	7
323	18745	3.1420	1	1	2	4	6
324	7509	1.8440	1	1	1	2	3
325	8989	3.7900	1	2	3	5	7
326	2820	2.6710	1	1	2	3	5
327	2	2.5000	1	1	4	4	4
328	690	3.7720	1	1	3	5	7
329	105	2.2000	1	1	1	2	5
331	49529	5.5840	1	3	4	7	11
332	5171	3.1690	1	1	2	4	6
333	321	4.6980	1	2	3	6	10
334	10358	4.7820	2	3	4	5	8
335	12477	3.1770	2	2	3	4	5
336	36484	3.4270	1	2	2	4	7
337	29676	2.0680	1	1	2	2	3
338	1057	5.5560	1	2	3	8	13
339	1518	4.6420	1	1	3	6	10
340	1	1.0000	1	1	1	1	1
341	3693	3.0630	1	1	2	3	6
342	726	3.1640	1	1	2	4	6
343	1	5.0000	5	5	5	5	5
344	3824	2.2880	1	1	1	2	4
345	1188	3.8760	1	1	2	4	8
346	4590	6.0320	1	3	5	8	12
347	379	2.6830	1	1	2	3	6
348	3308	4.1570	1	2	3	5	8
349	605	2.4740	1	1	2	3	5
350	6535	4.5040	2	2	4	6	8
351	1	1.0000	1	1	1	1	1
352	774	3.9810	1	2	3	5	8
353	2685	6.4640	2	3	5	7	12
354	7532	5.8240	3	3	4	7	10
355	5709	3.2350	2	2	3	4	5
356	26094	2.1720	1	1	2	3	4
357	5753	8.4210	3	4	6	10	16
358	20771	4.3060	2	3	3	5	7
359	31334	2.6370	1	2	3	3	4
360	15680	2.8180	1	2	2	3	5
361	371	3.6500	1	1	2	4	8
362	4	1.2500	1	1	1	1	2
363	2701	3.6410	1	2	2	4	7
364	1643	3.8820	1	1	3	5	8

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V19.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
365	1793	7.3830	1	3	5	9	16
366	4469	6.8500	2	3	5	9	14
367	526	3.0080	1	1	2	4	6
368	3302	6.7190	2	3	5	8	13
369	3304	3.1880	1	1	2	4	6
370	1286	5.6890	3	3	4	5	9
371	1479	3.5800	2	3	3	4	5
372	939	3.7150	1	2	2	3	5
373	3974	2.2870	1	2	2	3	3
374	122	2.8770	1	2	2	3	5
375	8	5.2500	1	3	5	5	9
376	266	3.5080	1	2	2	4	6
377	31	4.1940	1	2	3	4	7
378	173	2.4800	1	1	2	3	5
379	416	2.9760	1	1	2	3	6
380	81	1.9750	1	1	1	2	4
381	187	2.1230	1	1	1	3	4
382	27	1.3330	1	1	1	1	2
383	1881	3.9530	1	1	3	4	8
384	156	2.7820	1	1	1	3	6
386	1	119.0000	119	119	119	119	119
389	7	8.7140	1	2	4	8	10
390	8	2.7500	1	1	1	4	5
392	2275	9.5310	2	4	7	12	20
393	1	2.0000	2	2	2	2	2
394	1971	6.3180	1	2	4	8	14
395	101315	4.3510	1	2	3	5	9
396	11	3.8180	1	1	2	4	6
397	18036	5.1720	1	2	4	7	10
398	17243	5.8910	2	3	5	7	11
399	1806	3.5480	1	2	3	5	7
400	6533	8.9770	1	3	6	11	20
401	5878	11.2420	2	5	9	15	23
402	1606	3.8890	1	1	3	5	8
403	32232	8.0040	2	3	6	10	17
404	4627	4.1950	1	2	3	5	9
406	2508	9.7210	2	4	7	12	20
407	704	4.1210	1	2	3	5	8
408	2142	7.8730	1	2	5	10	18
409	2534	6.1220	2	3	4	6	12
410	30971	4.0150	1	2	4	5	6
411	14	2.9290	1	1	2	4	6
412	18	2.0000	1	1	1	2	4
413	5811	7.3080	2	3	6	9	14
414	771	4.0100	1	2	3	5	8
415	40210	14.5010	4	6	11	18	29
416	181965	7.4660	2	4	6	9	15
417	41	6.1710	1	2	4	8	14
418	23577	6.1810	2	3	5	8	12
419	15866	4.6500	1	2	4	6	9
420	2980	3.4310	1	2	3	4	6
421	9327	3.7870	1	2	3	4	7
422	70	2.9570	1	1	2	3	6
423	7327	8.2410	2	3	6	10	17
424	1308	12.9440	2	5	9	16	26
425	16394	3.8990	1	2	3	5	8
426	4535	4.4740	1	2	3	5	9
427	1609	4.4410	1	2	3	5	9
428	757	7.3750	1	2	4	8	15
429	27186	6.1440	2	3	4	7	12
430	63771	7.9550	2	3	6	10	16
431	328	5.9390	1	2	4	7	13
432	423	4.5820	1	1	3	5	9
433	5584	2.9750	1	1	2	3	6
439	1473	8.5030	1	3	6	10	17
440	5503	9.0500	2	3	6	11	20
441	625	3.0740	1	1	2	4	7
442	16855	8.5610	1	3	6	10	18
443	3849	3.5180	1	1	3	4	7
444	5747	4.3170	1	2	3	5	8

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V19.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
445	2784	2.8980	1	1	2	4	5
447	6305	2.4430	1	1	2	3	5
448	1	1.0000	1	1	1	1	1
449	30763	3.6800	1	1	3	4	8
450	7473	1.9840	1	1	1	2	4
451	5	1.6000	1	1	2	2	2
452	25447	5.0230	1	2	3	6	10
453	5690	2.7650	1	1	2	3	5
454	4688	4.3390	1	2	3	5	9
455	1114	2.3700	1	1	2	3	5
461	4611	4.1010	1	1	2	4	10
462	12023	11.3750	4	6	10	14	21
463	25420	4.1700	1	2	3	5	8
464	7177	3.0080	1	1	2	4	6
465	227	2.8770	1	1	1	3	5
466	1824	4.0780	1	1	2	4	7
467	1063	8.4440	1	1	2	3	6
468	57546	12.8910	3	6	10	16	25
471	12545	5.5070	3	3	4	6	9
473	8303	12.3500	1	3	7	17	32
475	104500	11.2180	2	5	9	15	22
476	3821	11.2580	2	5	10	15	21
477	25818	8.1450	1	3	6	11	17
478	109191	7.3850	1	3	5	9	16
479	24297	3.3010	1	1	3	4	7
480	649	21.7670	7	9	14	28	51
481	750	22.0970	13	17	20	25	34
482	5619	13.2190	4	7	10	16	25
483	43462	39.9080	15	22	33	49	72
484	331	13.0510	2	5	10	18	27
485	3084	9.4890	4	5	7	11	18
486	1988	12.2010	1	5	10	16	25
487	3690	7.6740	1	3	6	10	16
488	782	16.8530	3	6	13	22	35
489	13676	8.5500	2	3	6	10	18
490	5331	5.2610	1	2	4	6	10
491	13680	3.4640	1	2	3	4	6
492	2898	15.0290	2	5	7	25	34
493	58389	5.8760	1	3	5	7	11
494	31161	2.4740	1	1	2	3	5
495	215	17.3070	8	10	13	20	31
496	1866	9.4750	3	4	7	11	19
497	20076	6.5420	3	4	5	7	11
498	14808	4.1250	2	3	4	5	6
499	32826	4.6350	1	2	3	6	9
500	49835	2.4640	1	1	2	3	5
501	2366	10.6200	4	5	8	13	20
502	643	6.3840	2	4	5	7	11
503	5941	3.8850	1	2	3	5	7
504	124	34.7980	9	15	27	44	66
505	149	3.7250	1	1	1	5	9
506	939	17.2470	4	8	14	22	36
507	289	8.9790	2	4	7	12	18
508	667	8.2220	2	3	6	10	17
509	179	5.6200	1	2	5	7	10
510	1679	6.6240	1	3	5	8	13
511	622	4.3750	1	1	3	5	9
512	481	14.4570	6	8	11	16	25
513	152	10.7570	5	7	9	11	20
514	19636	7.3000	1	3	6	10	15
515	4638	5.5020	1	1	3	7	13
516	76643	4.7310	2	2	4	6	9
517	192533	2.6120	1	1	2	3	6
518	51888	3.3920	1	1	2	4	7
519	7288	5.1560	1	2	3	6	12
520	11196	2.1150	1	1	2	2	4
521	28838	5.7890	2	3	4	7	12
522	6195	9.4550	3	4	8	12	20
523	15001	4.0880	1	2	3	5	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V19.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
	11483663						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)

[FY 2001 MEDPAR Update March 2002 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	27930	11.1260	3	5	8	14	22
2	14166	5.2220	1	3	4	7	10
3	7	7.4290	1	1	3	4	10
4	6510	7.1900	1	2	5	9	16
5	93559	3.0670	1	1	2	3	7
6	398	2.9200	1	1	2	4	6
7	14289	9.7760	1	4	7	12	20
8	4389	2.7520	1	1	1	3	6
9	1755	6.4550	1	3	5	8	13
10	18163	6.5160	2	3	5	8	13
11	3444	4.0010	1	2	3	5	8
12	49862	5.8770	2	3	4	7	11
13	6731	5.0160	2	3	4	6	9
14	236626	6.0820	2	3	5	7	12
15	102255	4.9520	2	3	4	6	9
16	9310	6.1410	2	3	5	8	12
17	2882	3.1380	1	1	2	4	6
18	28194	5.4260	2	3	4	7	10
19	8749	3.5380	1	2	3	5	7
20	5666	10.4560	3	5	8	13	20
21	1445	6.5690	2	3	5	8	13
22	2737	5.0080	2	2	4	6	10
23	11274	4.2370	1	2	3	5	8
24	55738	4.8890	1	2	4	6	10
25	27443	3.2300	1	2	3	4	6
26	35	4.6290	1	1	2	4	6
27	3897	5.0160	1	1	3	6	11
28	12468	6.2410	1	3	5	8	13
29	4987	3.5570	1	2	3	5	7
31	3887	4.0710	1	2	3	5	8
32	1940	2.4380	1	1	2	3	5
34	22860	5.0270	1	2	4	6	9
35	7575	3.2120	1	1	3	4	6
36	2513	1.4700	1	1	1	1	2
37	1437	3.8040	1	1	2	4	8
38	93	2.4950	1	1	1	3	6
39	671	1.9400	1	1	1	2	4
40	1534	3.6140	1	1	2	5	8
42	1951	2.3660	1	1	1	3	5
43	111	3.0270	1	1	2	4	6
44	1302	5.0340	2	3	4	6	9
45	2619	3.2440	1	2	3	4	6
46	3394	4.5840	1	2	4	6	9
47	1359	3.1660	1	1	3	4	6
48	1	2.0000	2	2	2	2	2
49	2347	4.6230	1	2	3	5	9
50	2492	1.8210	1	1	1	2	3
51	254	3.1260	1	1	1	3	7
52	242	1.9130	1	1	1	2	3
53	2528	3.3780	1	1	2	4	8
54	1	4.0000	4	4	4	4	4
55	1583	3.0580	1	1	1	3	6
56	535	2.9780	1	1	2	3	6
57	696	3.7400	1	1	2	4	8
59	129	2.6740	1	1	1	3	6
60	6	3.3330	1	1	2	5	5
61	244	4.7830	1	1	3	6	10
62	3	1.6670	1	1	1	3	3
63	2951	4.4780	1	1	3	6	9
64	3168	6.5990	1	2	4	8	14
65	39160	2.7980	1	1	2	3	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
66	7719	3.1100	1	1	2	4	6
67	441	3.5940	1	2	3	4	6
68	8805	3.8300	1	2	3	5	7
69	3059	2.9940	1	2	2	4	5
70	25	3.4800	1	2	3	4	8
71	87	3.4370	1	2	3	4	6
72	934	3.5630	1	1	3	4	7
73	7115	4.3800	1	2	3	6	9
75	40165	10.0590	3	5	7	12	20
76	41905	11.4330	3	5	9	14	22
77	2458	4.8650	1	2	4	7	10
78	35476	6.6620	3	4	6	8	11
79	166958	8.5080	3	4	7	11	16
80	8364	5.4950	2	3	5	7	10
81	2	8.0000	3	3	13	13	13
82	63860	6.9900	2	3	6	9	14
83	6521	5.4790	2	3	4	7	10
84	1602	3.2040	1	2	3	4	6
85	21367	6.3180	2	3	5	8	12
86	2192	3.8090	1	2	3	5	8
87	59754	6.3130	1	3	5	8	12
88	398448	5.1060	2	3	4	6	9
89	504650	5.8910	2	3	5	7	11
90	47050	4.0300	2	2	3	5	7
91	55	4.0180	2	2	3	5	9
92	14891	6.3630	2	3	5	8	12
93	1721	4.1100	1	2	3	5	8
94	12688	6.3310	2	3	5	8	13
95	1704	3.7280	1	2	3	5	7
96	54007	4.5510	2	2	4	6	8
97	28779	3.5190	1	2	3	4	6
98	15	5.0000	1	2	3	4	13
99	21402	3.1730	1	1	2	4	6
100	9013	2.1320	1	1	2	3	4
101	21303	4.3870	1	2	3	6	9
102	5618	2.5720	1	1	2	3	5
103	453	51.8520	9	14	27	64	130
104	19595	14.4100	6	8	12	17	25
105	27398	9.9560	5	6	8	11	18
106	3320	11.4070	5	7	10	14	20
107	86073	10.4600	5	7	9	12	17
108	6235	10.2790	3	5	8	13	20
109	59810	7.7310	4	5	6	9	13
110	53439	9.0380	2	4	7	11	18
111	9446	4.4130	1	2	4	6	8
113	41687	12.4870	4	6	9	15	24
114	8909	8.5190	2	4	7	11	17
115	15348	8.2670	1	4	7	11	16
116	109696	4.4720	1	2	3	6	9
117	4196	4.1630	1	1	2	5	10
118	8135	2.8930	1	1	1	3	7
119	1322	5.1060	1	1	3	6	12
120	37631	8.7880	1	2	6	11	20
121	167946	6.3300	2	3	5	8	12
122	82148	3.6130	1	2	3	5	7
123	41344	4.7020	1	1	3	6	11
124	138962	4.3690	1	2	3	6	8
125	90577	2.7430	1	1	2	4	5
126	5061	11.9020	4	6	9	15	22
127	684796	5.2710	2	3	4	7	10
128	8303	5.4670	2	3	5	7	9
129	4150	2.8310	1	1	1	3	6
130	89193	5.6610	2	3	5	7	10
131	27944	4.0540	1	2	4	5	7
132	152950	2.9290	1	1	2	4	5
133	8979	2.2630	1	1	2	3	4
134	39813	3.1770	1	2	2	4	6
135	7584	4.4210	1	2	3	5	8
136	1243	2.5710	1	1	2	3	5
138	204244	3.9830	1	2	3	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
139	90369	2.4820	1	1	2	3	5
140	66769	2.5570	1	1	2	3	5
141	102878	3.5910	1	2	3	4	7
142	51988	2.5540	1	1	2	3	5
143	251435	2.0830	1	1	2	3	4
144	89218	5.4560	1	2	4	7	11
145	7647	2.6530	1	1	2	3	5
146	10845	10.2150	5	7	8	12	17
147	2812	6.3970	3	5	6	8	10
148	130042	12.2930	5	7	10	15	22
149	19445	6.4620	4	5	6	8	10
150	20434	11.2310	4	7	10	14	20
151	5000	5.6690	1	3	5	8	10
152	4436	8.3290	3	5	7	10	14
153	2027	5.3860	3	4	5	7	8
154	29150	13.2280	3	7	10	16	26
155	7319	3.9840	1	2	3	6	8
156	3	15.0000	11	11	13	21	21
157	8205	5.5530	1	2	4	7	11
158	4604	2.5160	1	1	2	3	5
159	17212	5.0630	1	2	4	6	10
160	12260	2.6480	1	1	2	3	5
161	11221	4.1550	1	1	3	5	9
162	7337	1.9150	1	1	1	2	4
163	3	3.0000	1	1	3	5	5
164	5142	8.2640	3	5	7	10	14
165	2201	4.6460	2	3	4	6	8
166	3935	4.8750	1	2	4	6	9
167	3833	2.5130	1	1	2	3	4
168	1409	4.8810	1	2	3	6	10
169	887	2.3160	1	1	2	3	5
170	15002	11.0580	2	5	8	14	22
171	1472	4.2760	1	2	3	6	8
172	30816	6.9650	2	3	5	9	14
173	2736	3.7380	1	1	3	5	8
174	248283	4.8070	2	3	4	6	9
175	35359	2.9190	1	2	3	4	5
176	15279	5.2510	2	3	4	6	10
177	9466	4.5110	2	2	4	6	8
178	3770	3.0770	1	2	3	4	6
179	12641	5.9620	2	3	5	7	11
180	88694	5.3720	2	3	4	7	10
181	27227	3.3760	1	2	3	4	6
182	262087	4.3630	1	2	3	5	8
183	91760	2.8830	1	1	2	4	5
184	94	2.8400	1	1	2	4	6
185	5155	4.6870	1	2	3	6	9
186	3	4.6670	2	2	3	9	9
187	698	4.1790	1	2	3	6	8
188	79822	5.5600	1	2	4	7	11
189	13196	3.0550	1	1	2	4	6
190	78	4.7690	1	2	3	5	8
191	9286	13.7420	3	6	10	17	28
192	1267	6.1130	1	3	5	8	11
193	4893	12.7480	5	7	10	16	23
194	738	6.8510	2	4	6	8	12
195	4171	10.3630	4	6	9	12	18
196	1056	5.4220	2	3	5	7	9
197	18696	8.9790	3	5	7	11	16
198	5707	4.4310	2	3	4	6	8
199	1663	9.9180	2	4	7	13	21
200	1049	10.4500	1	3	7	14	22
201	2020	14.5070	4	6	11	18	29
202	26324	6.3730	2	3	5	8	13
203	29515	6.7410	2	3	5	9	13
204	61935	5.8110	2	3	4	7	11
205	24648	6.1690	2	3	5	8	12
206	2068	3.9160	1	2	3	5	8
207	32279	5.1810	1	2	4	7	10
208	10815	2.8610	1	1	2	4	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
209	373009	4.9900	3	3	4	6	8
210	122166	6.8910	3	4	6	8	11
211	32764	4.9270	3	4	5	6	7
212	7	3.2860	1	2	2	2	4
213	9936	9.1390	2	4	7	11	18
216	6966	9.5420	2	4	7	12	19
217	17192	13.4090	3	5	9	16	28
218	23017	5.4590	2	3	4	7	10
219	21116	3.2120	1	2	3	4	5
220	1	2.0000	2	2	2	2	2
223	13773	2.8810	1	1	2	3	6
224	12585	1.8630	1	1	1	2	3
225	6183	5.0260	1	2	3	7	11
226	5746	6.6640	1	3	5	8	14
227	4975	2.6700	1	1	2	3	5
228	2509	4.0880	1	1	2	5	9
229	1194	2.2140	1	1	2	3	4
230	2432	5.0670	1	2	3	6	11
231	12627	4.8920	1	1	3	6	11
232	885	2.7380	1	1	1	3	7
233	7875	7.7800	1	3	6	10	16
234	4676	3.1670	1	1	2	4	7
235	5116	5.0300	1	2	4	6	9
236	40046	4.7420	1	3	4	6	9
237	1761	3.6000	1	2	3	4	7
238	8678	8.8670	3	4	7	11	17
239	48474	6.2820	2	3	5	8	12
240	11901	6.7280	2	3	5	8	13
241	3252	3.8840	1	2	3	5	7
242	2531	6.5780	2	3	5	8	13
243	94344	4.6810	1	2	4	6	9
244	13655	4.7310	1	2	4	6	9
245	5760	3.3620	1	2	3	4	6
246	1350	3.7580	1	2	3	5	7
247	19731	3.3700	1	1	3	4	7
248	12158	4.8690	1	2	4	6	9
249	12733	3.6440	1	1	2	4	7
250	3838	4.1640	1	2	3	5	7
251	2517	2.7750	1	1	2	4	5
253	21017	4.6730	1	3	4	6	9
254	10910	3.1320	1	2	3	4	6
255	1	2.0000	2	2	2	2	2
256	6435	5.1150	1	2	4	6	10
257	16786	2.6640	1	1	2	3	5
258	17062	1.8180	1	1	2	2	3
259	3835	2.6770	1	1	1	2	6
260	5111	1.3670	1	1	1	1	2
261	1927	2.1650	1	1	1	2	4
262	688	4.2920	1	1	3	5	10
263	24727	11.8360	3	5	8	14	23
264	4016	6.9110	2	3	5	8	14
265	4092	6.7790	1	2	4	8	14
266	2697	3.1350	1	1	2	4	6
267	272	4.2170	1	1	2	4	8
268	925	3.5950	1	1	2	4	8
269	9738	8.4120	2	3	6	11	17
270	2865	3.3910	1	1	2	4	7
271	19734	7.2900	2	4	6	9	13
272	5508	6.1320	2	3	5	7	12
273	1389	3.9270	1	2	3	5	7
274	2368	6.7490	1	3	5	8	14
275	255	3.0120	1	1	2	4	6
276	1337	4.5030	1	2	4	6	8
277	94462	5.7610	2	3	5	7	10
278	31992	4.2750	2	3	4	5	7
279	4	6.7500	3	3	6	8	10
280	17235	4.1620	1	2	3	5	8
281	7951	2.9070	1	1	2	4	5
283	5674	4.6490	1	2	4	6	9
284	1960	3.0550	1	1	2	4	6

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
285	6641	10.6710	3	5	8	13	20
286	2193	5.9450	2	3	4	7	11
287	6513	10.5590	3	5	8	12	20
288	3757	5.3890	2	3	4	6	8
289	6449	2.8110	1	1	1	3	6
290	9553	2.2290	1	1	1	2	4
291	78	1.6030	1	1	1	2	3
292	6125	10.6910	2	4	8	14	22
293	371	5.0650	1	2	3	7	11
294	95967	4.5380	1	2	3	6	9
295	3387	3.9770	1	2	3	5	7
296	252270	5.1150	1	2	4	6	10
297	47995	3.3570	1	2	3	4	6
298	109	4.2750	1	2	3	5	7
299	1225	5.3900	1	2	4	6	10
300	17627	6.1590	2	3	5	8	12
301	3661	3.6680	1	2	3	5	7
302	8130	8.6850	4	5	7	10	15
303	20806	8.2750	3	4	6	9	15
304	12148	8.6900	2	4	6	11	18
305	3033	3.6060	1	2	3	5	6
306	7239	5.4920	1	2	3	7	13
307	2175	2.1990	1	1	2	3	4
308	7283	6.2730	1	2	4	8	14
309	4356	2.1520	1	1	2	3	4
310	24716	4.3420	1	1	3	5	9
311	8387	1.8230	1	1	1	2	3
312	1557	4.4950	1	1	3	6	10
313	646	2.1250	1	1	1	2	4
314	1	5.0000	5	5	5	5	5
315	34008	7.2120	1	1	4	9	17
316	115890	6.5900	2	3	5	8	13
317	1913	3.0910	1	1	2	3	7
318	5785	6.0350	1	3	4	8	12
319	503	2.8330	1	1	2	3	6
320	194230	5.3020	2	3	4	7	10
321	30917	3.7520	1	2	3	5	7
322	68	3.7350	1	2	3	5	7
323	18745	3.1420	1	1	2	4	6
324	7509	1.8440	1	1	1	2	3
325	8989	3.7900	1	2	3	5	7
326	2820	2.6710	1	1	2	3	5
327	2	2.5000	1	1	4	4	4
328	690	3.7720	1	1	3	5	7
329	105	2.2000	1	1	1	2	5
331	49529	5.5840	1	3	4	7	11
332	5171	3.1690	1	1	2	4	6
333	321	4.6980	1	2	3	6	10
334	10358	4.7820	2	3	4	5	8
335	12477	3.1770	2	2	3	4	5
336	36484	3.4270	1	2	2	4	7
337	29676	2.0680	1	1	2	2	3
338	1057	5.5560	1	2	3	8	13
339	1518	4.6420	1	1	3	6	10
340	1	1.0000	1	1	1	1	1
341	3693	3.0630	1	1	2	3	6
342	726	3.1640	1	1	2	4	6
343	1	5.0000	5	5	5	5	5
344	3852	2.3750	1	1	1	2	5
345	1343	4.7770	1	1	3	6	11
346	4590	6.0320	1	3	5	8	12
347	379	2.6830	1	1	2	3	6
348	3308	4.1570	1	2	3	5	8
349	605	2.4740	1	1	2	3	5
350	6535	4.5040	2	2	4	6	8
351	1	1.0000	1	1	1	1	1
352	774	3.9810	1	2	3	5	8
353	2685	6.4640	2	3	5	7	12
354	7532	5.8240	3	3	4	7	10
355	5709	3.2350	2	2	3	4	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
356	26094	2.1720	1	1	2	3	4
357	5753	8.4210	3	4	6	10	16
358	20771	4.3060	2	3	3	5	7
359	31334	2.6370	1	2	3	3	4
360	15680	2.8180	1	2	2	3	5
361	371	3.6500	1	1	2	4	8
362	4	1.2500	1	1	1	1	2
363	2701	3.6410	1	2	2	4	7
364	1643	3.8820	1	1	3	5	8
365	1863	7.7040	2	3	5	10	17
366	4469	6.8500	2	3	5	9	14
367	526	3.0080	1	1	2	4	6
368	3302	6.7190	2	3	5	8	13
369	3304	3.1880	1	1	2	4	6
370	1286	5.6890	3	3	4	5	9
371	1479	3.5800	2	3	3	4	5
372	939	3.7150	1	2	2	3	5
373	3974	2.2870	1	2	2	3	3
374	122	2.8770	1	2	2	3	5
375	8	5.2500	1	3	5	5	9
376	266	3.5080	1	2	2	4	6
377	31	4.1940	1	2	3	4	7
378	173	2.4800	1	1	2	3	5
379	416	2.9760	1	1	2	3	6
380	81	1.9750	1	1	1	2	4
381	187	2.1230	1	1	1	3	4
382	27	1.3330	1	1	1	1	2
383	1881	3.9530	1	1	3	4	8
384	156	2.7820	1	1	1	3	6
386	1	119.0000	119	119	119	119	119
389	7	8.7140	1	2	4	8	10
390	8	2.7500	1	1	1	4	5
392	2275	9.5310	2	4	7	12	20
393	1	2.0000	2	2	2	2	2
394	2349	7.0870	1	2	5	9	15
395	101315	4.3510	1	2	3	5	9
396	11	3.8180	1	1	2	4	6
397	18036	5.1720	1	2	4	7	10
398	17243	5.8910	2	3	5	7	11
399	1806	3.5480	1	2	3	5	7
400	6533	8.9770	1	3	6	11	20
401	5878	11.2420	2	5	9	15	23
402	1606	3.8890	1	1	3	5	8
403	32232	8.0040	2	3	6	10	17
404	4627	4.1950	1	2	3	5	9
406	2508	9.7210	2	4	7	12	20
407	704	4.1210	1	2	3	5	8
408	2142	7.8730	1	2	5	10	18
409	2534	6.1220	2	3	4	6	12
410	30971	4.0150	1	2	4	5	6
411	14	2.9290	1	1	2	4	6
412	18	2.0000	1	1	1	2	4
413	5811	7.3080	2	3	6	9	14
414	771	4.0100	1	2	3	5	8
415	40210	14.5010	4	6	11	18	29
416	181965	7.4660	2	4	6	9	15
417	41	6.1710	1	2	4	8	14
418	23577	6.1810	2	3	5	8	12
419	15866	4.6500	1	2	4	6	9
420	2980	3.4310	1	2	3	4	6
421	9327	3.7870	1	2	3	4	7
422	70	2.9570	1	1	2	3	6
423	7327	8.2410	2	3	6	10	17
424	1308	12.9440	2	5	9	16	26
425	16394	3.8990	1	2	3	5	8
426	4535	4.4740	1	2	3	5	9
427	1609	4.4410	1	2	3	5	9
428	757	7.3750	1	2	4	8	15
429	27186	6.1440	2	3	4	7	12
430	63771	7.9550	2	3	6	10	16

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
431	328	5.9390	1	2	4	7	13
432	423	4.5820	1	1	3	5	9
433	5584	2.9750	1	1	2	3	6
439	1473	8.5030	1	3	6	10	17
440	5503	9.0500	2	3	6	11	20
441	625	3.0740	1	1	2	4	7
442	16855	8.5610	1	3	6	10	18
443	3849	3.5180	1	1	3	4	7
444	5747	4.3170	1	2	3	5	8
445	2784	2.8980	1	1	2	4	5
447	6305	2.4430	1	1	2	3	5
448	1	1.0000	1	1	1	1	1
449	30763	3.6800	1	1	3	4	8
450	7473	1.9840	1	1	1	2	4
451	5	1.6000	1	1	2	2	2
452	25447	5.0230	1	2	3	6	10
453	5690	2.7650	1	1	2	3	5
454	4688	4.3390	1	2	3	5	9
455	1114	2.3700	1	1	2	3	5
461	4611	4.1010	1	1	2	4	10
462	12023	11.3750	4	6	10	14	21
463	25420	4.1700	1	2	3	5	8
464	7177	3.0080	1	1	2	4	6
465	227	2.8770	1	1	1	3	5
466	1824	4.0780	1	1	2	4	7
467	1063	8.4440	1	1	2	3	6
468	50164	12.9990	3	6	10	17	25
471	12545	5.5070	3	3	4	6	9
473	8303	12.3500	1	3	7	17	32
475	104500	11.2180	2	5	9	15	22
476	3821	11.2580	2	5	10	15	21
477	25809	8.1370	1	3	6	11	17
478	109191	7.3850	1	3	5	9	16
479	24297	3.3010	1	1	3	4	7
480	649	21.7670	7	9	14	28	51
481	750	22.0970	13	17	20	25	34
482	5372	12.5700	4	7	9	15	24
483	43709	39.8370	14	22	33	49	71
484	331	13.0510	2	5	10	18	27
485	3084	9.4890	4	5	7	11	18
486	1988	12.2010	1	5	10	16	25
487	3690	7.6740	1	3	6	10	16
488	782	16.8530	3	6	13	22	35
489	13676	8.5500	2	3	6	10	18
490	5329	5.2600	1	2	4	6	10
491	13680	3.4640	1	2	3	4	6
492	2898	15.0290	2	5	7	25	34
493	58389	5.8760	1	3	5	7	11
494	31161	2.4740	1	1	2	3	5
495	215	17.3070	8	10	13	20	31
496	1866	9.4750	3	4	7	11	19
497	20076	6.5420	3	4	5	7	11
498	14808	4.1250	2	3	4	5	6
499	32826	4.6350	1	2	3	6	9
500	49835	2.4640	1	1	2	3	5
501	2366	10.6200	4	5	8	13	20
502	643	6.3840	2	4	5	7	11
503	5941	3.8850	1	2	3	5	7
504	124	34.7980	9	15	27	44	66
505	149	3.7250	1	1	1	5	9
506	939	17.2470	4	8	14	22	36
507	289	8.9790	2	4	7	12	18
508	667	8.2220	2	3	6	10	17
509	179	5.6200	1	2	5	7	10
510	1679	6.6240	1	3	5	8	13
511	622	4.3750	1	1	3	5	9
512	481	14.4570	6	8	11	16	25
513	152	10.7570	5	7	9	11	20
514	19636	7.3000	1	3	6	10	15
515	4638	5.5020	1	1	3	7	13

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY (LOS)—Continued

[FY 2001 MEDPAR Update March 2002 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
516	61977	4.7310	2	2	4	6	9
517	151552	2.6120	1	1	2	3	6
518	51888	3.3920	1	1	2	4	7
519	7288	5.1560	1	2	3	6	12
520	11196	2.1150	1	1	2	2	4
521	28838	5.7890	2	3	4	7	12
522	6195	9.4550	3	4	8	12	20
523	15001	4.0880	1	2	3	5	7
524	137407	3.3970	1	2	3	4	6
525	497	16.3000	2	5	9	18	36
526	14666	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
527	40981	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
	11483663						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) JULY 2002

State	Urban	Rural
ALABAMA	0.338	0.395
ALASKA	0.408	0.676
ARIZONA	0.345	0.473
ARKANSAS	0.430	0.435
CALIFORNIA	0.328	0.412
COLORADO	0.411	0.532
CONNECTICUT	0.494	0.509
DELAWARE	0.516	0.484
DISTRICT OF COLUMBIA	0.415	
FLORIDA	0.343	0.358
GEORGIA	0.457	0.453
HAWAII	0.410	0.519
IDAHO	0.558	0.543
ILLINOIS	0.392	0.487
INDIANA	0.488	0.526
IOWA	0.471	0.596
KANSAS	0.380	0.587
KENTUCKY	0.477	0.487
LOUISIANA	0.389	0.482
MAINE	0.580	0.517
MARYLAND	0.759	0.821
MASSACHUSETTS	0.514	0.560
MICHIGAN	0.460	0.562
MINNESOTA	0.460	0.585
MISSISSIPPI	0.444	0.424
MISSOURI	0.397	0.474
MONTANA	0.504	0.536
NEBRASKA	0.428	0.547
NEVADA	0.282	0.473
NEW HAMPSHIRE	0.524	0.587
NEW JERSEY	0.356	
NEW MEXICO	0.472	0.516
NEW YORK	0.487	0.595
NORTH CAROLINA	0.512	0.465
NORTH DAKOTA	0.609	0.555
OHIO	0.492	0.566
OKLAHOMA	0.390	0.474
OREGON	0.545	0.577

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) JULY 2002—Continued

State	Urban	Rural
PENNSYLVANIA	0.375	0.499
PUERTO RICO	0.470	0.561
RHODE ISLAND	0.486	
SOUTH CAROLINA	0.438	0.456
SOUTH DAKOTA	0.490	0.552
TENNESSEE	0.429	0.457
TEXAS	0.381	0.483
UTAH	0.495	0.584
VERMONT	0.580	0.599
VIRGINIA	0.451	0.543
WASHINGTON	0.581	0.595
WEST VIRGINIA	0.569	0.549
WISCONSIN	0.518	0.595
WYOMING	0.446	0.614

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 2002

State	Ratio
ALABAMA	0.042
ALASKA	0.053
ARIZONA	0.037
ARKANSAS	0.045
CALIFORNIA	0.032
COLORADO	0.046
CONNECTICUT	0.036
DELAWARE	0.048
DISTRICT OF COLUMBIA	0.033
FLORIDA	0.041
GEORGIA	0.048
HAWAII	0.039
IDAHO	0.047
ILLINOIS	0.039
INDIANA	0.050

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) JULY 2002—Continued

State	Ratio
IOWA	0.047
KANSAS	0.047
KENTUCKY	0.046
LOUISIANA	0.045
MAINE	0.037
MARYLAND	0.013
MASSACHUSETTS	0.050
MICHIGAN	0.044
MINNESOTA	0.042
MISSISSIPPI	0.042
MISSOURI	0.042
MONTANA	0.051
NEBRASKA	0.047
NEVADA	0.031
NEW HAMPSHIRE	0.059
NEW JERSEY	0.031
NEW MEXICO	0.045
NEW YORK	0.048
NORTH CAROLINA	0.047
NORTH DAKOTA	0.068
OHIO	0.047
OKLAHOMA	0.043
OREGON	0.042
PENNSYLVANIA	0.037
PUERTO RICO	0.041
RHODE ISLAND	0.031
SOUTH CAROLINA	0.046
SOUTH DAKOTA	0.051
TENNESSEE	0.049
TEXAS	0.043
UTAH	0.046
VERMONT	0.049
VIRGINIA	0.056
WASHINGTON	0.067
WEST VIRGINIA	0.045
WISCONSIN	0.050
WYOMING	0.055

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2003

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
010005	01	3440	3440
010008	01	5240	
010010	01	3440	3440
010012	01	2880	
010022	01	2880	
010029	0580	1800	
010035	01	1000	
010036	01	2750	
010043	01	1000	1000
010072	01	0450	0450
010101	01	0450	0450
010118	01	5240	
010120	01	5160	
010121	01	5240	
010126	01	2180	
010150	01	5240	
010158	01	2650	
020008	02	0380	
030007	03	2620	
030012	03	6200	
030033	03	2620	
030043	03	8520	
040014	04	4400	
040017	04	7920	
040019	04	4920	
040020	3700	4920	
040026	04	4400	
040027	04	7920	
040041	04	4400	
040045	04	26	
040066	04	4400	
040069	04	4920	
040076	04	4400	
040078	04	4400	
040080	04	3700	
040088	04	7680	
040091	04	8360	
040107	04	8360	
040119	04	4400	
050042	05	6690	
050045	05		7320
050069	5945	4480	
050071	7400	5775	
050073	8720	5775	
050076	7360	5775	
050101	8720	5775	
050150	05	6920	
050174	7500	8720	
050228	7360	5775	
050230	5945	4480	
050236	8735	4480	
050296	05	7120	
050301	05	7500	
050325	05	5170	
050335	05	5170	
050419	05	6690	
050457	7360	5775	
050464	5170	8120	
050494	05	6920	
050510	7360	5775	
050541	7360	5775	
050549	8735	4480	
050569	05	7500	
050594	5945	4480	
050609	5945	4480	
050686	6780	5945	
050701	6780	7320	
060003	1125	2080	2080
060013	06	0200	
060018	06	2995	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2003—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
060023	2995	6520	
060027	1125	2080	2080
060044	06	2080	
060049	06	2080	
060075	06	2995	
060076	06	3060	
060096	06	2080	
060103	1125	2080	2080
070006	5483	5600	
070018	5483	5600	
070033	5483	5600	
070034	5483	5600	
070036	3283	5483	
080002	08		0720
080004	2190	9160	
080006	08	2190	
080007	08	2190	
100022	5000	2680	
100023	10	5960	
100024	10	5000	
100045	2020	5960	
100049	10	3980	
100098	10	8960	8960
100103	10	3600	3600
100105	10	2710	
100109	10	5960	
100150	10	5000	
100157	3980	8280	
100176	8960	2710	
100217	10	2710	
100232	10	2900	2900
100239	8280	7510	
100249	10	8280	
100268	8960	2680	
110001	11	0520	
110002	11	0520	
110003	11	3600	
110016	11	1800	
110023	11	0520	
110025	11	3600	
110029	11	0520	
110038	11	10	
110040	11	0500	0500
110050	11	0520	
110054	11	0520	
110075	11	7520	
110100	11	0600	
110118	11	0120	
110122	11	10	
110150	11	4680	
110168	11	0520	
110187	11	0520	
110188	11	0520	
110189	11	0520	
110190	11	4680	
110205	11	0520	
130002	13	29	
130003	13	6740	
130011	13	50	
130049	13	7840	
140012	14	1600	
140015	14	7040	
140031	14	1400	
140032	14	7040	
140034	14	7040	
140040	14	1960	
140043	14	6880	
140046	14	7040	
140058	14	7880	
140064	14	6120	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2003—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
140086	14		7040
140093	14	1400	
140102	14	7880	7880
140110	14	6120	
140141	14	7040	7040
140143	14	6120	
140155	3740		1600
140160	14	6880	
140161	14	1600	
140164	14	7040	
140189	14	1400	
140199	14	7040	
140230	14		1400
140234	14	6120	
140245	14		7040
140271	14	7800	7800
150002	2960	1600	
150004	2960	1600	
150006	15	7800	
150008	2960	1600	
150011	15	3480	3480
150015	15	1600	
150027	15		3480
150030	15	3480	3480
150034	2960	1600	
150036	15	3850	
150048	15	2000	
150051	1020		3480
150062	15	3480	3480
150065	15	3480	
150067	15		3480
150069	15	1640	1640
150076	15	7800	
150090	2960	1600	
150096	15	2330	
150105	15	3480	3480
150112	15	3480	3480
150122	15	3480	
150125	2960	1600	1600
150126	2960	1600	1600
150132	2960	1600	
150133	15	2330	
150146	15	2330	
160001	16	2120	
160016	16	2120	
160026	16	2120	
160030	16	2120	
160037	16	24	
160057	16	3500	
160064	16	8920	
160080	16	6880	
160089	16	2120	
160094	16	8920	
160122	16	14	
160147	16	2120	
170001	17	9040	
170006	17	3710	
170010	17	8560	
170012	17	9040	
170013	17	9040	
170014	17	3760	
170020	17	9040	
170022	17	7000	
170023	17	9040	
170025	17	9040	
170033	17	9040	
170058	17	26	
170060	17	28	
170094	17	8440	
170120	17	3710	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2003—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
170131	17		8440
170142	17	8440	
170145	17	8560	
170166	17	0320	
170175	17	9040	
180005	18	3400	
180011	18	4280	
180012	18	4520	
180013	18	5360	
180016	18	4520	
180018	18	4280	
180027	18	1660	
180028	18	3400	
180029	18	3660	
180044	18	3400	
180048	18	4280	
180054	18	1660	
180065	18	1640	
180066	18	5360	
180069	18	3400	
180078	18	3400	
180102	18	1660	
180104	18	1660	
180116	18	1660	
180124	18	5360	
180127	18	4520	
180132	18	4280	
180139	18	4280	
190001	19	5560	5560
190003	19	3880	
190010	19	5560	5560
190014	19	3880	
190015	19	5560	
190018	19	3880	
190025	19	3880	
190054	19	3880	
190083	19	5200	
190086	19	5200	
190099	19	3880	
190106	19	3880	
190131	19	5560	
190218	19	0220	
200020	6403	1123	1123
200024	4243	6403	
200034	4243	6403	
200039	20	6403	
200040	6403		1123
200063	20	6403	
220060	1123	0743	
220077	8003	3283	
230015	23	3720	
230022	23	3720	
230027	23	3000	3000
230030	23	6960	
230036	23	6960	
230037	23	0440	
230040	23	3720	3000
230054	23	3080	
230080	23	6960	
230093	23	3000	
230096	23	3720	
230097	23	3000	
230105	23	6960	
230106	23	3000	
230121	23	2640	2640
230188	23	6960	6960
230199	23	0870	0870
230235	23	6960	6960
230253	23	2160	
240008	24	6820	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2003—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
240011	24	5120	
240014	24	5120	
240016	24	2520	
240018	24		5120
240023	24	5120	
240045	24	2240	
240064	24	2240	
240075	24	6980	
240088	24	6980	
240089	24	5120	
240100	24	2985	
240121	24	2240	
240139	24	5120	
240142	24	6980	
240152	24	5120	
250004	25	4920	
250009	25	3580	
250012	25	4920	
250025	25	01	
250030	25	3560	
250031	25	3560	
250034	25	4920	
250042	25	4920	
250058	25	3285	
250069	25	3560	
250078	3285	0920	
250079	25	3560	
250081	25	3560	
250082	25	6240	
250084	25	19	
250088	25	0760	
250094	3285	0920	
250097	25	0760	
250100	25	8600	
250101	25	3560	
250104	25	3560	
250122	25	19	
250126	25	4920	
260009	26	3760	
260011	26	1740	
260015	26	3700	
260017	26	7040	
260022	26	1740	
260025	26	14	
260034	26	3760	
260047	26	1740	
260050	26	7000	
260064	26	1740	
260074	26	1740	
260078	26	7920	
260094	26	7920	
260110	26	7040	7040
260113	26	14	
260116	26	7040	
260119	26	3700	
260120	26	3700	
260127	26	7040	
260131	26	1740	
260183	26	7040	
260186	26	1740	
270002	27	0880	
270003	27	3040	
270011	27	3040	
270016	27	0880	
270017	27	5140	
270051	27	5140	
270057	27	0880	
270083	27	5140	
280009	28	4360	
280023	28	4360	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2003—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
280032	28	4360	
280054	28	4360	
280061	28	53	
280065	28	3060	
280077	28	5920	
280111	28	5920	
280125	28	7720	
290006	29	6720	
290019	29	6720	
300003	30	1123	
300005	30	1123	1123
300019	30	1123	
300024	30		1123
310001	0875	5600	
310002	5640	5600	
310003	3640	5600	
310015	5640	0875	
310021	8480	5190	
310031	6160	5190	
310038	5015	5600	
310045	0875	5600	
310048	5015	5640	
310049	3640		5640
310070	5015	5640	
310076	5640	5600	
310087	8760	6160	
310118	3640		0875
310119	5640	5600	
320005	32	0200	
320006	32	7490	
320011	32	7490	
320013	32	7490	
320063	32	5800	
320065	32	5800	
330001	5660	5600	
330004	33	5660	
330023	2281	5660	
330027	5380	5600	
330084	33	1303	
330085	33	8160	
330103	33		1280
330106	5380	5600	
330126	5660	5600	
330135	5660	5600	
330136	33	8160	
330157	33	8160	
330181	5380	5600	
330182	5380	5600	
330205	5660	5600	
330209	5660	5600	
330224	33	3283	
330235	8160		6840
330239	3610	2360	
330250	33	1303	
330264	5660	5600	
330307	33	8160	
330386	33	5660	
340003	34	3120	
340008	34	2560	
340013	34	1520	
340017	34	0480	
340021	34	1520	
340023	34	0480	
340027	34	3150	
340039	34	1520	1520
340050	34	2560	
340051	34	3290	
340052	3120	1520	
340064	34	3120	
340068	34	9200	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2003—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
340071	34	6640	6640
340084	34	1520	
340088	34	0480	
340097	34	3120	
340109	34	5720	5720
340115	34	6640	
340124	34	6640	6640
340126	34	6640	6640
340129	34	1520	
340131	34	3150	
340143	3290	1520	
340144	34	1520	
340147	6895	6640	
350005	35	2985	
350006	35	1010	
350009	35	2520	
350017	35	27	
350043	35	1010	
360002	36		1680
360008	36	3400	
360010	36	0080	
360011	36	1840	
360013	36	2000	
360014	36	1840	
360024	36	1680	1680
360025	36	1680	1680
360036	36	0080	
360039	36	1840	
360046	3200	1640	
360046	3200		1640
360056	3200	1640	1640
360063	36	1680	1680
360065	36	1680	1680
360071	36	4320	4320
360076	3200	1640	1640
360078	0080		1680
360084	1320	0080	
360088	36	1840	
360089	36	8400	
360090	8400		2160
360092	36	1840	1840
360095	36	8400	
360107	36	8400	
360109	36	1840	
360112	8400	0440	
360121	36	0440	
360132	3200	1640	1640
360142	36		1640
360159	36	1840	
360175	36	1840	1640
360197	36	1840	1840
360211	8080		6280
370004	37	3710	
370006	37	8560	
370014	37	7640	
370015	37	8560	
370018	37	8560	
370022	37	4200	
370023	37	4200	
370025	37	8560	
370034	37	2720	
370047	37	7640	
370048	37	8360	
370049	37	5880	
370054	37	5880	
370084	37	2720	
370103	37	45	
370153	37	4200	
370200	37	5880	
380001	38	6440	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2003—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
380002	38	4890	
380003	38	2400	
380006	38		6440
380027	38	2400	
380040	38	2400	
380047	38	2400	
380050	38	4890	
380051	7080		6440
380065	38	2400	
380070	38	6440	
380090	38	2400	
390006	39	3240	
390008	39	6280	6280
390013	39	3240	
390016	39	6280	6280
390017	39	6280	6280
390030	39	0240	6680
390031	39	0240	6680
390048	39	3240	
390052	39	0280	
390065	39	9280	9280
390079	39	0960	
390091	39	6280	
390093	39	6280	
390110	3680	6280	
390113	39	9320	
390133	0240	6160	
390138	39	8840	
390150	39	6280	
390151	39	8840	
390181	39	6680	6680
390183	39	6680	6680
390189	39	3240	
390197	0240	6160	
390201	39	5660	5640
390263	0240	6160	
400018	40	1310	
410010	6483	1123	
410013	6483	5523	
420020	42	1440	
420036	42	1520	
420059	42	2655	
420062	42	1520	
420068	42	0600	
420070	8140	1760	
420071	42	0600	
420080	42	7520	
420085	5330	9200	
430008	43	24	
430012	43	7760	
430013	43	7760	
430014	43	2520	
430015	43	6660	
430047	43	28	
430048	43	53	
430089	43	7720	
440020	44	3440	
440024	44	1560	
440050	44	0480	
440058	44	1560	
440059	44	5360	
440067	44	3840	
440068	44	1560	
440073	44	5360	
440083	44	3840	
440143	44	5360	
440148	44	5360	
440175	44	3440	
440180	44	3840	
440182	44	3580	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2003—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
440185	44	1560	
440186	44	5360	
440187	44	18	
440192	44	5360	
440200	44	5360	
440203	44	1560	
450007	45	7240	
450014	45	8750	
450053	45	8750	
450072	1145	3360	
450080	45	4420	
450085	45	9080	
450098	45	4420	
450099	45	0320	
450113	45	1920	
450140	45	5800	
450144	45	5800	
450146	45	0320	
450155	45	0320	
450163	45	1880	
450178	45	5800	
450187	45	3360	
450192	45	1920	
450194	45	1920	
450196	45		1920
450211	45	3360	
450214	45	3360	
450224	45	8640	
450246	45	8750	
450347	45	3360	
450351	45	2800	
450353	45	1880	
450373	45	4420	
450395	45	3360	
450400	45	8800	
450438	45	0640	
450447	45	1920	
450451	45	2800	
450484	45	3360	
450508	45	8640	
450534	45	0320	
450587	45	40	
450591	1145	3360	
450623	45	1920	
450626	45	8750	
450653	45	5800	
450656	45	8640	
450694	45	3360	
450747	45	1920	
450755	45	4600	
450763	45	0320	
460007	46	2620	
460011	46	6520	
460021	46	4120	
460027	46	6520	
460032	46	6520	
460036	46	6520	
460039	46	7160	
470001	47	1303	
470003	1303	1123	
470011	47	1123	
470012	47	6323	
470018	47	1123	
490001	49	3660	
490004	49	1540	
490005	49	8840	
490013	49	4640	
490013	49	4640	
490018	49	4640	
490038	49	3660	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2003—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
490047	49	8840	
490060	49	3660	
490066	5720	6760	
490079	49	3120	
490126	49	6800	
500002	50	6740	
500003	50	0860	
500007	50	0860	
500016	50	7600	
500041	50	6440	
500059	50	7600	
500072	50	7600	
500079	8200		7600
510001	51	6280	
510002	51	6800	
510006	51	6280	
510024	51	6280	6280
510028	51	1480	
510046	51	1480	
510047	51	6280	
510048	51	3400	
510062	51	1480	
510070	51	1480	
510071	51	1480	
520002	52	8940	
520006	52	8940	
520011	52	2290	
520021	3800	1600	1600
520028	52	4720	
520037	52	8940	
520059	6600	5080	5080
520066	3620	4720	
520071	52	5080	5080
520076	52	5080	
520084	52	4720	
520088	52	5080	
520091	52	23	
520094	6600	5080	5080
520096	6600	5080	5080
520102	52	5080	5080
520107	52	3080	
520113	52	3080	
520116	52	5080	5080
520152	52	3080	
520173	52	2240	
520189	3800	1600	1600
530008	53	1350	
530009	53	1350	
530015	53	6340	
530025	53	2670	
530032	53	7160	

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]

DRG	Cases	Mean + 1 standard deviation
1	27,927	$67,404
2	14,163	$34,673
3	7	$55,408
4	6,509	$42,448
5	93,493	$23,377
6	398	$14,176
7	14,289	$47,294
8	4,388	$28,479
9	1,755	$24,328
10	18,159	$22,402
11	3,442	$15,623
12	49,827	$15,545
13	6,724	$14,071
14	236,532	$22,079
15	102,208	$17,030
16	9,310	$21,738
17	2,881	$11,621
18	28,178	$17,142
19	8,743	$12,381
20	5,664	$52,181
21	1,445	$27,499
22	2,736	$18,514
23	11,272	$14,333
24	55,718	$17,446
25	27,441	$10,729
26	35	$13,582
27	3,897	$23,356

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
28	12,463	$23,965
29	4,983	$12,571
31	3,886	$15,438
32	1,938	$9,262
34	22,854	$17,458
35	7,567	$11,230
36	2,500	$11,056
37	1,436	$18,198
38	93	$9,804
39	670	$10,605
40	1,534	$15,129
42	1,949	$11,426
43	111	$8,988
44	1,302	$11,316
45	2,617	$12,432
46	3,392	$13,759
47	1,359	$9,362
49	2,347	$31,479
50	2,487	$14,084
51	254	$16,545
52	241	$13,058
53	2,527	$20,711
55	1,581	$16,320
56	533	$16,518
57	696	$17,549
59	128	$13,267
60	6	$11,274
61	244	$22,144
62	3	$6,890
63	2,951	$25,340
64	3,167	$24,013
65	39,149	$9,556
66	7,717	$9,940
67	440	$13,390
68	8,803	$11,627
69	3,058	$8,692
70	25	$8,204
71	87	$12,273
72	934	$12,534
73	7,112	$13,972
75	40,140	$53,811
76	41,890	$50,645
77	2,458	$21,413
78	35,432	$22,310
79	166,819	$29,146
80	8,348	$15,446
81	2	$17,847
82	63,839	$25,767
83	6,516	$17,174
84	1,601	$8,832
85	21,359	$21,704
86	2,191	$12,369
87	59,718	$24,643
88	398,067	$15,709
89	504,109	$18,189
90	47,012	$10,687
91	55	$12,834
92	14,880	$21,707
93	1,720	$13,033
94	12,685	$20,773
95	1,704	$10,355
96	53,963	$13,061
97	28,764	$9,660
98	15	$16,638
99	21,397	$12,340
100	9,004	$9,303
101	21,294	$15,036
102	5,616	$9,571

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
103	453	$367,290
104	19,589	$131,533
105	27,384	$95,106
106	3,319	$121,971
107	85,921	$86,478
108	6,230	$96,053
109	59,743	$64,368
110	53,431	$71,935
111	9,445	$42,825
113	41,664	$49,537
114	8,907	$29,181
115	15,346	$58,990
116	109,614	$38,674
117	4,196	$23,243
118	8,129	$27,230
119	1,322	$22,803
120	37,629	$39,645
121	167,925	$27,188
122	82,126	$17,938
123	41,332	$28,224
124	138,910	$24,070
125	90,494	$18,102
126	5,060	$48,433
127	684,227	$17,486
128	8,288	$12,396
129	4,144	$19,235
130	89,165	$16,499
131	27,920	$9,868
132	152,896	$11,175
133	8,967	$9,360
134	39,803	$10,380
135	7,582	$15,485
136	1,243	$10,044
138	204,170	$14,405
139	90,329	$8,871
140	66,747	$9,167
141	102,861	$12,675
142	51,974	$9,733
143	251,298	$9,258
144	89,188	$21,492
145	7,643	$10,459
146	10,841	$46,208
147	2,810	$26,054
148	129,948	$59,703
149	19,421	$24,836
150	20,430	$49,593
151	4,999	$22,731
152	4,435	$33,464
153	2,026	$19,581
154	29,142	$74,212
155	7,318	$21,983
156	3	$32,555
157	8,202	$22,136
158	4,600	$11,003
159	17,205	$23,466
160	12,246	$13,619
161	11,219	$19,197
162	7,321	$10,715
163	3	$7,938
164	5,140	$39,260
165	2,200	$20,663
166	3,934	$24,735
167	3,833	$14,845
168	1,408	$22,688
169	887	$12,798
170	15,000	$50,814
171	1,472	$20,737
172	30,796	$24,650

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
173	2,735	$13,887
174	248,141	$17,311
175	35,336	$9,600
176	15,273	$18,631
177	9,458	$15,796
178	3,768	$11,708
179	12,638	$18,986
180	88,639	$16,610
181	27,216	$9,290
182	262,029	$14,023
183	91,740	$10,011
184	94	$8,737
185	5,154	$15,723
186	3	$17,875
187	696	$15,067
188	79,797	$19,450
189	13,187	$10,387
190	78	$12,670
191	9,283	$78,241
192	1,267	$31,130
193	4,890	$60,095
194	738	$27,831
195	4,164	$50,676
196	1,055	$26,257
197	18,684	$43,002
198	5,702	$21,036
199	1,663	$43,294
200	1,049	$53,896
201	2,020	$67,946
202	26,312	$23,150
203	29,505	$24,900
204	61,908	$20,516
205	24,637	$21,268
206	2,067	$12,532
207	32,271	$19,957
208	10,811	$11,475
209	372,279	$31,962
210	122,061	$29,462
211	32,711	$19,985
212	7	$12,150
213	9,933	$32,907
216	6,966	$39,219
217	17,187	$54,066
218	23,006	$25,987
219	21,106	$16,879
223	13,759	$17,261
224	12,552	$12,912
225	6,183	$19,662
226	5,746	$27,178
227	4,970	$13,622
228	2,509	$19,610
229	1,194	$11,847
230	2,432	$22,178
231	12,624	$24,201
232	883	$16,540
233	7,874	$37,126
234	4,676	$22,187
235	5,113	$13,085
236	40,000	$12,274
237	1,760	$9,994
238	8,670	$25,013
239	48,442	$17,681
240	11,894	$23,382
241	3,248	$11,495
242	2,530	$20,034
243	94,301	$13,030
244	13,641	$12,510
245	5,755	$8,412

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
246	1,350	$9,972
247	19,727	$10,064
248	12,150	$14,678
249	12,731	$11,854
250	3,835	$11,911
251	2,517	$8,099
253	20,998	$12,813
254	10,902	$7,704
256	6,431	$14,288
257	16,772	$14,857
258	17,039	$11,449
259	3,835	$15,369
260	5,097	$11,113
261	1,923	$16,946
262	688	$15,991
263	24,718	$38,028
264	4,016	$19,611
265	4,092	$27,441
266	2,697	$14,755
267	272	$16,075
268	925	$19,327
269	9,735	$30,555
270	2,865	$13,392
271	19,721	$18,266
272	5,507	$17,536
273	1,389	$10,100
274	2,368	$22,159
275	255	$10,372
276	1,336	$12,114
277	94,344	$15,014
278	31,948	$9,512
279	4	$17,604
280	17,227	$12,112
281	7,944	$8,057
283	5,671	$12,657
284	1,960	$7,644
285	6,638	$36,255
286	2,193	$35,893
287	6,511	$33,003
288	3,757	$37,255
289	6,442	$16,278
290	9,537	$14,936
291	78	$10,617
292	6,124	$48,257
293	371	$24,926
294	95,924	$13,312
295	3,386	$13,866
296	252,123	$14,853
297	47,964	$8,755
298	109	$10,034
299	1,225	$16,331
300	17,611	$19,532
301	3,657	$11,338
302	8,130	$55,527
303	20,794	$41,559
304	12,145	$41,008
305	3,031	$20,757
306	7,236	$22,022
307	2,171	$10,310
308	7,283	$28,400
309	4,351	$15,334
310	24,707	$19,400
311	8,377	$10,521
312	1,557	$18,584
313	646	$11,827
315	34,005	$37,125
316	115,837	$23,854
317	1,913	$12,529

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
318	5,782	$21,457
319	503	$11,336
320	194,070	$14,798
321	30,891	$9,599
322	68	$9,132
323	18,744	$14,366
324	7,505	$8,164
325	8,988	$11,522
326	2,819	$7,922
327	2	$10,762
328	690	$13,079
329	105	$8,710
331	49,515	$18,870
332	5,169	$10,822
333	321	$14,080
334	10,350	$25,041
335	12,465	$18,158
336	36,467	$14,411
337	29,659	$9,712
338	1,057	$21,551
339	1,518	$18,614
341	3,693	$21,558
342	726	$13,124
344	3,851	$22,634
345	1,342	$19,650
346	4,587	$19,105
347	379	$10,965
348	3,306	$12,913
349	605	$7,299
350	6,529	$12,505
352	774	$12,969
353	2,680	$32,047
354	7,526	$25,751
355	5,700	$14,571
356	26,077	$12,521
357	5,750	$40,024
358	20,759	$20,246
359	31,287	$13,396
360	15,672	$14,701
361	371	$18,705
362	4	$8,407
363	2,700	$15,699
364	1,643	$14,803
365	1,863	$34,638
366	4,465	$23,452
367	525	$10,167
368	3,299	$21,265
369	3,302	$10,746
370	1,284	$16,225
371	1,476	$10,644
372	939	$9,848
373	3,971	$6,378
374	122	$12,746
375	8	$21,571
376	265	$8,744
377	31	$23,435
378	173	$15,122
379	416	$6,917
380	81	$6,607
381	186	$10,262
382	27	$3,014
383	1,881	$9,372
384	156	$7,467
389	7	$34,427
390	8	$13,005
392	2,274	$56,008
394	2,346	$31,726
395	101,259	$14,419

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
396	11	$12,914
397	17,989	$21,897
398	17,236	$22,492
399	1,806	$12,364
400	6,531	$47,849
401	5,876	$50,482
402	1,606	$19,867
403	32,218	$32,326
404	4,622	$15,977
406	2,507	$49,500
407	703	$21,974
408	2,142	$36,720
409	2,532	$21,881
410	30,961	$18,459
411	14	$7,772
412	18	$5,007
413	5,810	$25,090
414	771	$12,969
415	40,196	$66,869
416	181,882	$28,337
417	41	$22,272
418	23,567	$18,479
419	15,855	$15,249
420	2,978	$10,242
421	9,323	$11,975
422	70	$7,706
423	7,321	$32,051
424	1,308	$41,557
425	16,388	$11,974
426	4,533	$9,233
427	1,609	$9,317
428	756	$13,065
429	27,167	$14,265
430	63,752	$12,736
431	327	$10,872
432	423	$11,180
433	5,581	$4,920
439	1,473	$29,717
440	5,498	$33,013
441	625	$15,811
442	16,846	$42,862
443	3,849	$17,778
444	5,746	$13,130
445	2,782	$8,545
447	6,305	$8,528
449	30,756	$14,340
450	7,469	$7,247
451	5	$4,128
452	25,432	$18,482
453	5,687	$9,170
454	4,687	$14,486
455	1,113	$8,155
461	4,611	$21,349
462	12,012	$20,019
463	25,409	$12,194
464	7,163	$8,706
465	227	$10,413
466	1,822	$11,632
467	1,063	$9,841
468	50,149	$67,712
470	56	$320,694
471	12,460	$47,823
473	8,302	$64,225
475	104,462	$67,821
476	3,820	$41,084
477	25,807	$32,999
478	109,163	$42,312
479	24,294	$24,477

TABLE 10.—MEANS AND STANDARD DEVIATIONS, BY DIAGNOSIS RELATED GROUPS (DRGS) [1]—Continued

DRG	Cases	Mean + 1 standard deviation
480	649	$180,578
481	750	$127,638
482	5,371	$62,963
483	43,690	$292,070
484	331	$100,727
485	3,084	$51,800
486	1,988	$86,227
487	3,687	$36,110
488	782	$88,702
489	13,667	$32,494
490	5,324	$18,378
491	13,649	$27,118
492	2,897	$75,913
493	58,366	$30,941
494	31,075	$16,839
495	215	$160,061
496	1,864	$99,536
497	20,068	$58,040
498	14,786	$41,923
499	32,816	$24,399
500	49,773	$15,631
501	2,362	$44,558
502	642	$25,718
503	5,937	$20,667
504	124	$284,775
505	149	$32,946
506	939	$85,181
507	289	$30,660
508	667	$24,870
509	179	$16,930
510	1,679	$20,594
511	622	$11,693
512	481	$98,319
513	152	$102,359
514	19,616	$104,642
515	4,636	$88,517
516	76,556	$42,776
517	191,887	$34,456
518	51,871	$30,445
519	7,284	$40,177
520	11,165	$25,193
521	28,831	$12,761
522	6,193	$10,048
523	14,988	$6,937
524	137,361	$12,413
525	497	$214,078
526	68,336	$34,435
527	189,145	$27,295

[1] Cases are taken from the FY 2001 MedPAR file; DRGs are from GROUPER V20.0.

Appendix A—Regulatory Impact Analysis

I. Introduction

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Public Law 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Public Law 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We have determined that this final rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the total impact of these changes for FY 2003 payments compared to FY 2002 payments to be approximately a $0.3 billion increase.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million to $25 million in any 1 year. For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the acute care hospital inpatient prospective payment systems, we classify these hospitals as urban hospitals.

It is clear that the changes being made in this document will affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Public Law 104–4) also requires that agencies assess anticipated costs and benefits before issuing a final rule that has been preceded by a proposed rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule will not mandate any requirements for State, local, or tribal governments.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this final rule in light of Executive Order 13132 and have determined that it will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

II. Objectives

The primary objective of the acute care hospital inpatient prospective payment system is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Trust Fund.

We believe the changes in this final rule will further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these changes will ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our policy changes, as well as statutory changes effective for FY 2003, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. As we have done in previous proposed rules, we solicited comments and information about the anticipated effects of these changes on hospitals and our methodology for estimating them.

We received several comments on the impact analysis for our May 9, 2002 proposed rule.

Comment: Several commenters noted that the effects of the proposed expansion to the postacute transfer policy were not included in the May 9, 2002 proposed rule impact tables. These commenters were concerned that the effect of implementing either of the two proposed expansions of this policy would result in an overall decrease in per case payments in FY 2003.

Response: We did not analyze the postacute care transfer policy in the impact tables in the proposed rule because we did not propose a specific policy expansion. We did include overall savings estimates attributable to the provision in the preamble discussion.

Comment: Several commenters noted the impact that the large legislated decreases in IME payments and the update factor (market basket increase minus 0.55 percentage point) will have on many hospitals. They argued that these decreases in payments, in combination with our proposals and an update factor of less than inflation, will have an even larger overall impact than indicated

in our impact tables. The commenters indicated that, in a time when other health care costs are escalating due to nursing shortages, rising drug and technology costs, and ''skyrocketing'' professional and general insurance premiums, hospitals cannot absorb a reduction in inpatient Medicare payments. They argued that decreasing payments and increasing costs will make hospitals less able to make decisions based solely on the needs of the beneficiary and make more decisions based on solvency.

Response: As the commenters pointed out, these reductions are legislated by Congress. However, as discussed further below, one of the biggest impacts on the changes in payments from FY 2002 to FY 2003 is the high outlier payments hospitals are receiving in FY 2002 (approximately 7.2 percent of total DRG payments) compared to the FY 2003 estimated 5.1 percent. The net effect of this difference is to reduce the rate of change by 2.1 percentage points.

IV. Hospitals Included in and Excluded From the Acute Care Hospital Inpatient Prospective Payment System

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general short-term, acute care hospitals that participate in the Medicare program. There were 44 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 67 such hospitals in Maryland remain excluded from the acute care hospital inpatient prospective payment system under the waiver at section 1814(b)(3) of the Act.

There are approximately 631 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the acute care hospital inpatient prospective payment system. The remaining 20 percent are specialty hospitals that are excluded from the acute care hospital inpatient prospective payment system. These hospitals include psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. The impacts of our final policy changes on these hospitals are discussed below.

Thus, as of July 2002, we have included 4,230 hospitals in our analysis. This represents about 80 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

V. Impact on Excluded Hospitals and Hospital Units

There were 1,065 specialty hospitals excluded from the acute care hospital inpatient prospective payment system. Broken down by specialty, there were 493 psychiatric, 216 rehabilitation, 270 long-term care, 75 children's, and 11 cancer hospitals. In addition, there were 1,436 psychiatric units and 936 rehabilitation units in hospitals otherwise subject to the acute care hospital inpatient prospective payment system. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 67 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

In the past, hospitals and units excluded from the acute care hospital inpatient prospective payment system have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid based on their reasonable costs are subject to TEFRA limits for FY 2003. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket (currently estimated at 3.5 percent).

Inpatient rehabilitation facilities (IRFs) are paid under the IRF prospective payment system for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2003, the IRF prospective payment is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually (see the August 7, 2001 final rule (66 FR 41316 through 41430)). Therefore, these hospitals are not impacted by this final rule.

Effective for cost reporting periods beginning during FY 2003, we have proposed that long-term care hospitals would be paid under a long-term care hospital prospective payment system, where long-term care hospitals receive payment based on a 5-year transition period (see the March 22, 2002 proposed rule (67 FR 13416 through 13494)). However, under this proposed payment system, a long-term care hospital may also elect to be paid at 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the proposed prospective payment system transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the long-term care hospital's TEFRA limit by the estimate of the excluded hospital market basket (or 3.5 percent).

The impact on excluded hospitals and hospital units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and hospital units receive. Conversely, for excluded hospitals and hospital units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect will be the amount of excess costs that would not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and hospital units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and hospital units to restrain the growth in their spending for patient services.

VI. Quantitative Impact Analysis of the Policy Changes Under the Hospital Inpatient Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this final rule, we are announcing policy changes and payment rate updates for the hospital inpatient prospective payment systems for operating and capital-related costs. We estimate the total impact of these changes for FY 2003 payments compared to FY 2002 payments to be approximately a $0.3 billion increase. We have prepared separate impact analyses of the changes to each system. This section deals with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the FY 2001 MedPAR file and the most current provider-specific file that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not incorporate cost data, the most recently available hospital cost report data were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these policy changes. Second, due to the interdependent nature of the hospital inpatient prospective payment system, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

Using cases in the FY 2001 MedPAR file, we simulated payments under the operating prospective payment system given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the acute care hospital inpatient prospective payment systems (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. The impact of payments under the capital prospective payment system, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of FY 2003 changes to the capital prospective payment system are discussed in section IX. of this Appendix.

The changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of the changes in hospitals' wage index values reflecting wage data from

hospitals' cost reporting periods beginning during FY 1999, compared to the FY 1998 wage data, and the effects of removing from the wage data the costs and hours associated with GME and CRNAs.

- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2003.
- The total change in payments based on FY 2003 policies relative to payments based on FY 2002 policies.

To illustrate the impacts of the FY 2003 changes, our analysis begins with a FY 2003 baseline simulation model using: the FY 2002 DRG GROUPER (version 19.0); the FY 2002 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG plus outlier payments.

Each final and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2003 model incorporating all of the changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 2002 to FY 2003. Six factors have significant impacts here. The first is the update to the standardized amounts. In accordance with section 1886(d)(3)(A)(iv) of the Act, as amended by section 301 of Public Law 106–554, we are updating the large urban and the other areas average standardized amounts for FY 2003 using the most recently forecasted hospital market basket increase for FY 2003 of 3.5 percent minus 0.55 percentage points (for an update of 2.95 percent). Under section 1886(b)(3) of the Act, the updates to the hospital-specific amounts for sole community hospitals (SCHs) and for Medicare-dependent small rural hospitals (MDHs) is also equal to the market basket increase of 3.5 percent minus 0.55 percentage points (for an update of 2.95 percent).

A second significant factor that impacts changes in hospitals' payments per case from FY 2002 to FY 2003 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2002 that are no longer reclassified in FY 2003 may have a negative payment impact going from FY 2002 to FY 2003; conversely, hospitals not reclassified in FY 2002 that are reclassified in FY 2003 may have a positive impact. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage change in payments for the category may be below the national mean. This effect is alleviated, however, by section 304(a) of Public Law 106-554, which provided that reclassifications for purposes of the wage index are for a 3-year period.

A third significant factor is that we currently estimate that actual outlier payments during FY 2002 will be 7.2 percent of total DRG payments. When the FY 2002 final rule was published, we projected FY 2002 outlier payments would be 5.1 percent of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2002 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 2002 payments per case to estimated FY 2003 payments per case.

Fourth, section 213 of Public Law 106–554 provided that all SCHs may receive payment on the basis of their costs per case during their cost reporting period that began during 1996. This option was to be phased in over 4 years. For FY 2003, the proportion of payments based on affected SCHs' FY 1996 hospital-specific amount increases from 50 percent to 75 percent.

Fifth, under section 1886(d)(5)(B)(ii) of the Act, the formula for IME is reduced beginning in FY 2003. The reduction is from approximately a 6.5 percent increase for every 10 percent increase in the resident-to-bed ratio during FY 2002 to approximately a 5.5 percent increase.

Comment: Numerous commenters expressed concern about the statutory reduction to the IME formula multiplier for FY 2003 of 1.35. The commenters stated that this cut in IME reimbursement will have any extremely detrimental impact on the teaching hospital community.

Response: Congress establishes the IME formula multiplier for FY 2003 by law. Any changes to the multiplier must be made through the legislative process.

Comment: One commenter stated that the reduction to the IME formula multiplier was not considered in the impact analysis table (67 FR 31670) in the proposed rule. The commenter requested that the large impact due to reduction in IME payments be acknowledged and weighed against the cost to hospitals that would be incurred by the proposed outlier reduction, transfer payment expansion, and the removal of resident salary costs from the wage index.

Response: In the May 9, 2002 proposed rule at 67 FR 31670 and 31671, we included several footnotes that explain the various calculations in the impact analysis for FY 2003. Footnote number 9 states that the impact of the reduction in IME adjustment payments is reflected in column 8 of the table, which contains all FY 2003 changes. Thus, we have incorporated the reduction to the IME formula multiplier in the impact analysis of total Medicare hospital expenditures for FY 2003, and have similarly done so in this final rule.

Sixth, the disproportionate share hospital (DSH) adjustment increases in FY 2003 compared with FY 2002. In accordance with section 1886(d)(5)(F)(ix) of the Act, during FY 2002, DSH payments that the hospital would otherwise receive were reduced by 3 percent. This reduction is no longer applicable beginning with FY 2003.

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 4,230 hospitals included in the analysis. This number is 555 fewer hospitals than were included in the impact analysis in the FY 2002 final rule (66 FR 40087). Of this number, 437 are now CAHs and are excluded from our analysis.

The next four rows of Table I contain hospitals categorized according to their geographic location: all urban, which is further divided into large urban and other urban; and rural. There are 2,620 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,519 hospitals located in large urban areas (populations over 1 million), and 1,101 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,610 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2003 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations after consideration of geographic reclassifications are 2,650, 1,576, 1,074, and 1,580, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 3,119 nonteaching hospitals in our analysis, 870 teaching hospitals with fewer than 100 residents, and 241 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Hospitals in the rural DSH categories, therefore, represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (They may, however, have been reclassified for purposes of the wage index.)

The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (160), SCHs (526), MDHs (241), and hospitals that are both SCH and RRC (76) shown here were not reclassified for purposes of the standardized amount.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 1999 Medicare cost report files, if available (otherwise FY 1998 data are used). Data needed to determine ownership status were unavailable for 177 hospitals. Similarly, the data needed to determine Medicare utilization were unavailable for 126 hospitals.

The next series of groupings concern the geographic reclassification status of hospitals. The first grouping displays all hospitals that were reclassified by the

MGCRB for FY 2003. The next two groupings separate the hospitals in the first group by urban and rural status. The final row in Table I contains hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act.

TABLE I—IMPACT ANALYSIS OF CHANGES FOR FY 2003, OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent changes in payments per case]

	Number of Hosps.[1]	Drg Changes	New wage data[3]	remove GMS and CRNA 80/20[4]	Remove GME and CRNA 100 percent[5]	DRG and WI changes[6]	MCGRB reclassification[7]	All FY 2003 changes[8]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
By Geographic Location:								
All hospitals	4,230	0.4	0.0	0.0	0.1	0.0 0	.0	0.4
Urban hospitals	2,620	0.5	0.0	0.0	0.1	0.0	−0.4	0.1
Large urban areas (populations over 1 million)	1,519	0.4	0.0	0.0	0.0	0.1	−0.5	0.2
Other urban areas (populations of 1 million of fewer)	1,101	0.5	0.0	0.1	0.1	0.1	0.4	0.7
Rural hospitals	1,610	.1	0.2	0.1	0.1	0.1	2.4	2.1
Bed Size (Urban):								
0–99 beds	645	0.3	0.0	0.1	0.1	0.0	−0.6	1.3
100–199 beds	909	0.3	−0.2	0.1	0.1	−0.3	−0.5	0.8
200–299 beds	523	0.5	0.0	0.1	0.1	0.0	−0.4	0.4
300–499 beds	398	0.6	−0.2	0.0	0.1	0.0	−0.4	−0.1
500 or more beds	145	0.6	0.2	0.0	0.0	0.2	−0.5	−0.6
Bed Size (Rural):								
0–49 beds	747	−0.3	0.3	0.1	0.1	−0.2	0.5	2.4
50–99 beds	501	−0.1	0.2	0.1	0.1	−0.1	0.9	2.3
100–149 beds	215	0.1	0.3	0.1	0.1	0.1	2.8	2.1
150–199 beds	78	0.2	0.2	0.1	0.1	0.1	4.9	1.8
200 or more beds	69	0.6	0.1	0.1	0.1	0.4	3.9	1.6
Urban by Region:								
New England	135	0.3	−0.1	0.1	0.1	0.6	−0.1	−0.3
Middle Atlantic	404	0.6	−0.4	0.0	−0.1	−0.5	0.1	−1.4
South Atlantic.	384	0.5	0.0	0.1	0.1	0.0	−0.5	0.7
East North Central	429	0.5	0.1	0.0	0.1	0.0	−0.5	0.2
East South Central	159	0.4	−0.1	0.0	0.0	−0.3	−0.7	0.6
West North Central	178	0.5	0.2	0.1	0.1	0.3	−0.7	0.6
West South Central	335	0.5	0.5	0.0	0.0	0.3	−0.7	1.0
Mountain	132	0.7	0.5	0.1	0.1	0.8	0.6	1.7
Pacific	417	0.3	−0.3	0.1	0.2	−0.3	−0.5	0.0
Puerto Rico	47	0.3	−0.8	0.0	0.0	−0.7	−0.8	0.6
Rural by Region:								
New England	40	0.2	0.2	0.0	0.0	0.1	2.7	1.1
Middle Atlantic	67	0.1	−0.5	0.0	0.0	−0.7	2.6	1.3
South Atlantic	232	0.1	0.1	0.1	0.1	−0.1	2.9	1.6
East North Central	215	0.3	0.1	0.1	0.1	0.2	2.3	2.6
East South Central	239	−0.1	0.7	0.1	0.1	0.3	2.5	2.0
West North Central	279	0.3	0.4	0.0	0.0	0.5	1.6	2.5
West South Central	285	−0.1	0.3	0.1	0.1	−0.1	3.2	2.0
Mountain	145	0.2	0.1	0.0	0.0	0.2	1.1	2.5
Pacific	103	0.1	0.3	0.1	0.1	0.2	2.3	2.3
Puerto Rico	5	0.1	−5.4	0.1	0.1	−5.6	−0.6	−2.7
By Payment Classification:								
Urban hospitals	2,650	0.5	0.0	0.0	0.1	0.0	−0.4	0.1
Large urban areas (populations over 1 million)	1,576	0.4	−0.1	1	0.0	−0.1	−0.4	−0.2
Other urban areas (populations of 1 million of fewer).	1,074	0.5	0.0	0.1	0.1	0.2	−0.4	0.7
Rural areas	1,580	0.1	0.2	0.1	0.1	0.1	2.3	2.1
Teaching Status:								
Non-teaching	3,119	0.3	0.0	0.1	0.1	0.0	0.3	1.3
Fewer than 100 Residents	870	0.6	−0.1	0.0	0.1	0.0	−0.3	0.5
100 or more Residents	241	0.5	0.0	0.0	0.0	0.0	−0.3	−1.4
Urban DSH:.								
Non-DSH	1,549	0.6	0.0	0.0	0.1	0.1	0.2	0.6
100 or more beds	1,361	0.4	0.0	0.0	0.1	−0.1	−0.5	0.0
Less than 100 beds	286	0.0	0.1	0.1	0.1	−0.2	−0.4	1.2
Rural DSH:								
.								
Sole Community (SCH)	470	−0.2	0.2	0.1	0.1	−0.1	0.2	2.5
Referral Center (RRC)	156	0.2	0.3	0.1	0.1	0.2	4.7	1.6
Other Rural:								
100 or more beds	76	0.0	0.3	0.1	0.1	−0.1	1.3	1.6

TABLE I—IMPACT ANALYSIS OF CHANGES FOR FY 2003, OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of Hosps.[1]	Drg Changes	New wage data[3]	remove GMS and CRNA 80/20[4]	Remove GME and CRNA 100 percent[5]	DRG and WI changes[6]	MCGRB reclassification[7]	All FY 2003 changes[8]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Less than 100 beds	332	−0.2	0.4	0.1	0.1	−0.2	0.6	2.0
Urban teaching and DSH:								
DSH	757	0.5	−0.1	0.0	0.0	0.0	−0.6	−0.4
Teaching and no DSH	284	0.7	0.0	0.0	0.0	0.1	0.0	−0.1
No teaching and DSH	890	0.3	0.0	0.1	0.1	−0.1	−0.4	1.1
No teaching and no DSH	719	0.5	−0.1	0.1	0.1	0.0	−0.4	0.7
Rural Hospital Types:								
Non special status hospitals	577	−0.1	0.4	0.1	0.1	−0.1	1.2	1.9
RRC	160	0.3	0.2	0.1	0.1	0.1	6.2	1.1
SCH	526	−0.1	0.2	0.0	0.0	0.0	0.2	2.7
Medicare-dependent hospitals (MDH)	241	−0.2	0.4	0.1	0.1	−0.1	0.6	2.5
SCH and RRC	76	0.5	0.1	0.0	0.0	0.6	1.3	3.1
Type of Ownership:								
Voluntary	2,461	0.5	0.0	0.0	0.1	0.0	0.0	0.4
Proprietary	723	0.4	0.1	0.1 0	.1	0.0	−0.1	0.4
Government	869	0.2	0.2	0.1	0.1	0.0	0.2	0.6
Unknown	5	177	0.4	−0.2	0.0	0.1	−0.3	−0.5
Medicare Utilization as a Percent of Inpatient Days:								
0–25	310	0.3	−0.1	0.1	0.1	−0.3	−0.3	−0.6
25–50	1,613	0.5	0.0	0.0	0.1	0.0	−0.3	0.0
50–65	1,677	0.4	0.0	0.1	0.1	0.0	0.3	1.0
Over 65	504	0.3	−0.1	0.0	0.1	−0.2	0.5	0.7
Unknown	126	0.9	0.1	0.0	0.0	0.3	−0.7	0.2
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2003 Reclassifications:								
All Reclassified Hospitals	628	0.4	0.0	0.1	0.1	0.2	4.5	1.2
Standardized Amount Only	28	0.2	−0.1	0.1	0.1	−0.3	0.3	1.0
Wage Index Only	521	0.4	0.1	0.1	0.1	0.2	4.7	0.8
Both	38	0.4	0.0	0.1	0.1	−0.1	5.5	0.8
Nonreclassified Hospitals	3,605	0.4	0.0	0.0	0.1	0.0	−0.7	0.3
All Reclassified Urban Hospitals	113	0.6	−0.2	0.0	0.1	0.1	4.5	0.1
Standardized Amount Only	11 0.2	−0.9	0.1	0.1	−1.2	−0.9	0.2	
Wage Index Only	87	0.7	−0.2	0.0	0.0	0.2	4.8	−0.2
Both	15	0.5	0.2	0.1	0.2	0.4	4.3	3.0
Urban Nonreclassified Hospitals	2,473	0.5	0.0	0.0	0.1	0.0	−0.7	0.1
All Reclassified Rural Hospitals	515	0.3	0.2	0.1	0.1	0.2	4.5	1.9
Standardized Amount Only	11	0.5	0.4	0.1	0.1	0.4	3.7	3.1
Wage Index Only	485	0.3	0.2	0.1	0.1	0.2	4.5	1.9
Both	19	0.3	−0.1	0.1	0.1	−0.1	5.9	1.8
Rural Nonreclassified Hospitals	1,094	−0.1	0.3	0.1	0.1	−0.1	−0.6	2.3
Other Reclassified Hospitals (Section 1886(D)(8)(B))	35	−0.1	−0.2	0.0	0.0	−0.9	−1.3	2.7

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2001, and hospital cost report data are from reporting periods beginning in FY 1999 and FY 1998.

[2] This column displays the payment impact of the recalibration of the DRG weights based on FY 2001 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[3] This column displays the impact of updating the wage index with wage data from hospitals' FY 1999 cost reports.

[4] This column displays the impact of an 80/20 percent blend of removing the labor costs and hours associated with graduate medical education (GME) and for the Part A costs of certified registered nurse anesthetists (CRNAs).

[5] This column displays the impact of completely removing the labor costs and hours associated with GME and for the Part A costs of CRNAs.

[6] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised wage data used to calculate the wage index, the phase-out of GME and CRNA costs and hours, and the budget neutrality adjustment factor for DRG and wage index changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 2, 3, 4 and 5, and the FY 2003 budget neutrality factor of 0.993209.

[7] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2003 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2003. Reclassification for prior years has no bearing on the payment impacts shown here.

[8] This column shows changes in payments from FY 2002 to FY 2003. It incorporates all of the changes displayed in columns 6 and 7 (the changes displayed in columns 2, 3, 4, and 5 are included in column 6). It also displays the impact of the FY 2003 update, changes in hospitals' reclassification status in FY 2003 compared to FY 2002, and the difference in outlier payments from FY 2002 to FY 2003. It also reflects the gradual phase-in for some SCHs of the full 1996 hospital-specific rate. Finally, the impacts of the reduction in IME adjustment payments, and the increase in the DSH adjustment are shown in this column. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effect.

B. Impact of the Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 2)

In column 2 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II. of the preamble to this final rule. Section 1886(d)(4)(C)(i) of the Act requires us to annually make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 2002 DRG relative weights (GROUPER version 19.0) to aggregate payments using the FY 2003 DRG relative weights (GROUPER version 20.0). We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we have applied a budget neutrality factor to ensure that the overall payment impact of the DRG changes (combined with the wage index changes) is budget neutral. This budget neutrality factor of 0.993209 is applied to payments in Column 6. Because this is a combined DRG reclassification and recalibration and wage index budget neutrality factor, it is not applied to payments in this column.

The DRG changes we are making will result in 0.4 percent higher payments to hospitals overall. This effect is largely attributable to the anticipated higher payments after April 1, 2003 for drug-eluting stents, as described in section II.B. of this final rule. Specifically, we created two new DRGs (526 and 527) to be effective April 1, 2003. The relative weights for these new DRGs are 14 and 16 percent higher, respectively, than the weights for current DRGs 516 and 517, the current DRGs for stents. Hospitals that are currently doing these procedures benefit demonstrate positive impacts from this change in this impact analysis.

Another change is to DRGs 14 (retitled, Intracranial Hemorrhage and Stroke with Infarction) and 15 (retitled, Nonspecific Cerebrovascular Accident and Precerebral Occlusion without Infarction), and new DRG 524 (Transient Ischemia). With the new configuration of these DRGs, over 100,000 cases that previously would have been assigned to DRG 14 (with a FY 2003 relative weight of 1.2943) will now be assigned to DRG 15 (with a FY 2003 relative weight of 0.9858).

Urban hospitals with 300 or more beds, and rural hospitals with 200 or more beds benefit from these changes. Rural hospitals with fewer than 50 beds would experience a 0.3 percent decrease due to these changes, and rural hospitals with between 50 and 99 beds would experience a 0.1 percent decrease. Among rural hospitals categorized by region, the East South Central and West South Central would experience a 0.1 percent decrease in payments. Among special rural hospital categories, SCHs would experience a 0.1 percent decrease and MDHs would experience a 0.2 percent decrease.

C. Impact of Wage Index Changes (Columns 3, 4, and 5)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the wage index for FY 2003 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1998 and before October 1, 1999. As with column 2, the impact of the new data on hospital payments is isolated in columns 3, 4 and 5 by holding the other payment parameters constant in the three simulations. That is, columns 3, 4, and 5 show the percentage changes in payments when going from a model using the FY 2002 wage index (based on FY 1997 wage data before geographic reclassifications to a model using the FY 2003 pre-reclassification wage index based on FY 1998 wage data).

The wage data collected on the FY 1999 cost reports are similar to the data used in the calculation of the FY 2002 wage index. Also, as described in section III.B of this preamble, the FY 2003 wage index is calculated by removing 100 percent of hospitals' GME and CRNA costs (and hours). The FY 2002 wage index was calculated by blending 60 percent of hospitals' average hourly wages, excluding GME and CRNA data, with 40 percent of average hourly wages including these data.

Column 3 shows the impacts of updating the wage data using FY 1999 cost reports. This column maintains the same 60/40 phase-out of GME and CRNA costs as the FY 2002 wage index, which is the baseline for comparison. Among regions, the largest impact of updating the wage data is seen in rural Puerto Rico (a 5.4 percent decrease). Rural hospitals in the East South Central region experience the next largest impact, a 0.7 percent increase. Among urban hospitals, Puerto Rico and the Middle Atlantic regions would experience a 0.8 and 0.4 percent decreases, respectively. The Mountain region would experience a 0.5 percent increase.

The next two columns show the impacts of removing the GME and CRNA data from the wage index calculation. Under the 5-year phaseout of these data, FY 2003 would have been the fourth year of the phaseout. This would have meant that, under the phaseout, the FY 2003 wage index would be calculated with 20 percent of the GME and CRNA data included and 80 percent with these data removed, and FY 2004 would begin the calculation with 100 percent of these data removed. However, we are removing 100 percent of GME and CRNA costs from the FY 2003 wage index. To demonstrate the impacts of this provision, we first show the impacts of moving to a wage index with 80 percent of these data removed (Column 4), then show a wage index with 100 percent of these data removed (Column 5). As expected, the impacts in the two columns are similar, with some differences due to rounding. Generally, no group of hospitals is impacted by more than 0.2 percent by this change. Even among the hospital group most likely to be negatively impacted by this change, teaching hospitals with 100 or more residents, the net effect of removing 100 percent of GME and CRNA data is no change in payments.

We note that the wage data used for the final wage index are based upon the data available as of July 2002 and, therefore, do not reflect revision requests received and processed by the fiscal intermediaries after that date.

The following chart compares the shifts in wage index values for labor market areas for FY 2002 relative to FY 2003. This chart demonstrates the impact of the changes for the FY 2003 wage index, including updating to FY 1999 wage data and removing 100 percent of GME and CRNA data. The majority of labor market areas (343) experience less than a 5-percent change. A total of 11 labor market areas experience an increase of more than 5 percent and less than 10 percent. Three areas experience an increase greater than 10 percent. A total of 15 areas experience decreases of more than 5 percent and less than 10 percent. Finally, 1 areas experience declines of 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 2002	FY 2003
Increase more than 10 percent	2	3
Increase more than 5 percent and less than 10 percent	26	11
Increase or decrease less than 5 percent	335	343
Decrease more than 5 percent and less than 10 percent	10	15
Decrease more than 10 percent	1	1

Among urban hospitals, 42 would experience an increase of between 5 and 10 percent and 9 more than 10 percent. A total of 22 rural hospitals have increases greater than 5 percent, but none have greater than 10-percent increases. On the negative side, 55 urban hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. Two urban hospitals have decreases in their wage index values greater than 10 percent. There are 17 rural hospitals with decreases in their wage index values greater than 5 percent or with increases of more than 10 percent. The following chart

shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	9	0
Increase more than 5 percent and less than 10 percent	42	22
Increase or decrease less than 5 percent	2553	1975
Decrease more than 5 percent and less than 10 percent	55	17
Decrease more than 10 percent	2	0

D. Combined Impact of DRG and Wage Index Changes—Including Budget Neutrality Adjustment (Column 6)

The impact of DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this final rule, we compared simulated aggregate payments using the FY 2002 DRG relative weights and wage index to simulated aggregate payments using the FY 2003 DRG relative weights and blended wage index. In addition, we are required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. As discussed in section II.D. of this final rule, we are approving one new technology for add-on payments in FY 2003. We estimate the total add-on payments for this new technology will be $74.8 million.

We computed a wage and recalibration budget neutrality factor of 0.993209. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 6. The 0.0 percent impact for all hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral.

In addition, section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. This provision is required to be budget neutral. The impact of this provision, which is to increase overall payments by 0.1 percent, is not shown in columns 2, 3, 4, and 5. It is included in the impacts shown in column 6.

The changes in this column are the sum of the changes in columns 2, 3, 4, and 5, combined with the budget neutrality factor and the wage index floor for urban areas. There also may be some variation of plus or minus 0.1 percentage point due to rounding.

E. Impact of MGCRB Reclassifications (Column 7)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 6 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2003. These decisions affect hospitals' standardized amount and wage index area assignments.

By February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using another area's standardized amount, wage index value, or both. The final FY 2003 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2003. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we applied an adjustment of 0.990672 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this final rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.4 percent in column 7. Payments to urban hospitals decline 0.4 percent. Hospitals in other urban areas see a decrease in payments of 0.4 percent, while large urban hospitals lose 0.5 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally decline.

A positive impact is evident among most of the rural hospital groups. The smallest increases among the rural census divisions are 1.1 and 1.6 percent for Mountain and West North Central regions, respectively. The largest increases are in rural South Atlantic and West South Central regions. These regions receive increases of 2.9 and 3.2 percent, respectively.

Among all the hospitals that were reclassified for FY 2003 (including hospitals that received wage index reclassifications in FY 2001 or FY 2002 that extend for 3-years), the MGCRB changes are estimated to provide a 4.5 percent increase in payments. Urban hospitals reclassified for FY 2003 are expected to receive an increase of 4.5 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 4.5 percent increase in payments. Overall, among hospitals that were reclassified for purposes of the standardized amount only, a payment increase of 0.3 percent is expected, while those reclassified for purposes of the wage index only show a 4.7 percent increase in payments. Payments to urban and rural hospitals that did not reclassify are expected to decrease slightly due to the MGCRB changes, decreasing by 0.7 for urban hospitals and 0.6 for rural hospitals. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive a decrease in payments of 1.3 percent.

F. All Changes (Column 8)

Column 8 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2003 (including statutory changes), to our estimate of payments per case in FY 2002. This column includes all of the policy changes to date. Because the reclassifications shown in column 7 do not reflect FY 2002 reclassifications, the impacts of FY 2003 reclassifications only affect the impacts from FY 2002 to FY 2003 if the reclassification impacts for any group of hospitals are different in FY 2003 compared to FY 2002.

It includes the effects of the 2.95 percent update to the standardized amounts and the hospital-specific rates for MDHs and SCHs. It also reflects the 2.1 percentage point difference between the projected outlier payments in FY 2002 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2002 (7.2 percent), as described in the introduction to this Appendix and the Addendum to this final rule.

Section 213 of Public Law 106–554 provided that all SCHs may receive payment on the basis of their costs per case during their cost reporting period that began during 1996. For FY 2003, eligible SCHs that rebase receive a hospital-specific rate comprised of 25 percent of the higher of their FY 1982 or FY 1987 hospital-specific rate or their Federal rate, and 75 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 8 as well.

Under section 1886(d)(5)(B)(ii) of the Act, the formula for IME is reduced beginning in FY 2003. The reduction is from approximately a 6.5 percent increase for every 10 percent increase in the resident-to-bed ratio during FY 2002 to approximately a 5.5 percent increase. We estimate the impact of this change to be a 0.9 percent reduction in hospitals' overall FY 2003 payments. The impact upon teaching hospitals would be larger.

Finally, the DSH adjustment increases in FY 2003 compared with FY 2002. In accordance with section 1886(d)(5)(F)(ix) of

the Act, during FY 2002, DSH payments that the hospital would otherwise receive were reduced by 3 percent. This reduction is no longer applicable beginning with FY 2003. The estimated impact of this change is to increase overall hospital payments by 0.2 percent.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 8 may not equal the sum of the changes in columns 6 and 7, plus the other impacts that we are able to identify.

The overall change in payments per case for hospitals in FY 2003 increases by 0.4 percent. Hospitals in urban areas experience a 0.1 percent increase in payments per case compared to FY 2002. Hospitals in rural areas, meanwhile, experience a 2.1 percent payment increase. Hospitals in large urban areas experience a 0.2 percent decline in payments, largely due to the reduction in IME payments. The impact of the reduction in IME payments is most evident among teaching hospitals with 100 or more residents, who would experience a decrease in payments per case of 1.4 percent.

Among urban census divisions, the largest payment increase was 1.7 percent in the Mountain region. Hospitals in urban Middle Atlantic would experience an overall decrease of 1.4 percent and hospitals in the New England region would experience a decrease of 0.3 percent. This is primarily due to the combination of the negative impact on these hospitals of reducing IME and the lower outlier payments during FY 2003. The only hospital category experiencing overall payment decreases is Puerto Rico, where payments decrease by 2.7 percent, largely due to the updated wage data. In the East North Central region, payments appear to increase by 2.6 percent. Mountain and West North Central regions also benefited, both with 2.5 percent increases.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) experience payment increases of 2.7 percent, 2.5 percent, and 3.1 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there are no outlier payments. Therefore, these hospitals do not experience negative payment impacts from the decline in outlier payments from FY 2002 to FY 2003 as do hospitals paid based on the national standardized amounts.

Hospitals that were reclassified for FY 2003 are estimated to receive a 1.2 percent increase in payments. Urban hospitals reclassified for FY 2003 are anticipated to receive an increase of 0.1 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 1.9 percent increase in payments. Overall, among hospitals reclassified for purposes of the standardized amount, a payment increase of 1.0 percent is expected, while those hospitals reclassified for purposes of the wage index only show an expected 0.8 percent increase in payments. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 2.7 percent.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Num. of hosps. (1)	Average FY 2002 payment per case[1] (2)	Average FY 2003 payment per case[1] (3)	All FY 2003 changes (4)
By Geographic Location:				
All hospitals	4,230	7,218	7247.2	0.4
Urban hospitals	2,620	7,718	7727.8	0.1
Large urban areas (populations over 1 million)	1,519	8,269	8249.2	−0.2
Other urban areas (populations of 1 million of fewer)	1,101	7,002	7050.4	0.7
Rural hospitals	1,610	5,168	5275.0	2.1
Bed Size (Urban):				
0–99 beds	645	5,309	5376.3	1.3
100–199 beds	909	6,424	6474.8	0.8
200–299 beds	523	7,394	7422.6	0.4
300–499 beds	398	8,345	8332.6	−0.1
500 or more beds	145	10,007	9943.6	−0.6
Bed Size (Rural):				
0–49 beds	747	4,260	4362.7	2.4
50–99 beds	501	4,776	4887.0	2.3
100–149 beds	215	5,106	5211.2	2.1
150–199 beds	78	5,515	5617.2	1.8
200 or more beds	69	6,750	6860.1	1.6
Urban by Region:				
New England	135	8,224	8203.0	−0.3
Middle Atlantic	404	8,789	8667.9	−1.4
South Atlantic	384	7,311	7360.5	0.7
East North Central	429	7,293	7311.6	0.2
East South Central	159	6,956	7000.5	0.6
West North Central	178	7,358	7404.2	0.6
West South Central	335	7,103	7172.5	1.0
Mountain	132	7,417	7546.6	1.7
Pacific	417	9,386	9385.9	0.0
Puerto Rico	47	3,319	3338.5	0.6
Rural by Region:				
New England	40	6,405	6475.6	1.1
Middle Atlantic	67	5,267	5338.0	1.3
South Atlantic	232	5,245	5330.7	1.6
East North Central	215	5,139	5275.2	2.6
East South Central	239	4,746	4843.1	2.0
West North Central	279	5,223	5354.7	2.5
West South Central	285	4,536	4626.7	2.0
Mountain	145	5,789	5933.2	2.5
Pacific	103	6,652	6803.3	2.3

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2003 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Num. of hosps. (1)	Average FY 2002 payment per case[1] (2)	Average FY 2003 payment per case[1] (3)	All FY 2003 changes (4)
Puerto Rico	5	2,753	2677.6	−2.7
By Payment Classification:				
Urban hospitals	2,650	7,703	7713.5	0.1
Large urban areas (populations over 1 million)	1,576	8,196	8180.0	−0.2
Other urban areas (populations of 1 million of fewer)	1,074	7,027	7075.0	0.7
Rural areas	1,580	5,155	5261.6	2.1
Teaching Status:				
Non-teaching	3,119	5,890	5965.9	1.3
Fewer than 100 Residents	870	7,475	7511.1	0.5
100 or more Residents	241	11,352	11196.8	−1.4
Urban DSH:				
Non-DSH	1,549	6,567	6604.7	0.6
100 or more beds	1,361	8,296	8299.2	0.0
Less than 100 beds	286	5,168	5232.1	1.2
Rural DSH:				
Sole Community (SCH)	470	4,942	5067.0	2.5
Referral Center (RRC)	156	5,974	6067.9	1.6
Other Rural:				
100 or more beds	76	4,517	4589.9	1.6
Less than 100 beds	332	4,089	4172.8	2.0
Urban teaching and DSH:				
Both teaching and DSH	757	9,177	9140.8	−0.4
Teaching and no DSH	284	7,773	7763.4	−0.1
No teaching and DSH	890	6,535	6608.4	1.1
No teaching and no DSH	719	6,041	6086.3	0.7
Rural Hospital Types:				
Non special status hospitals	577	4,261	4341.7	1.9
RRC	160	5,677	5737.5	1.1
SCH	526	5,280	5420.1	2.7
Medicare-dependent hospitals (MDH)	241	4,048	4150.6	2.5
SCH and RRC	76	6,626	6829.3	3.1
Type of Ownership:				
Voluntary	2,461	7,342	7369.6	0.4
Proprietary	723	6,945	6969.7	0.4
Government	869	6,809	6851.5	0.6
Unknown	177	7,302	7318.9	0.2
Medicare Utilization as a Percent of Inpatient Days:				
0–25	310	9,845	9786.3	−0.6
25–50	1,613	8,267	8268.6	0.0
50–65	1,677	6,257	6318.9	1.0
Over 65	504	5,647	5684.7	0.7
Unknown	126	8,992	9011.1	0.2
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2002 Reclassifications:				
All Reclassified Hospitals	628	6,530	6609.5	1.2
Standardized Amount Only	28	5,971	6029.0	1.0
Wage Index Only	521	6,749	6805.1	0.8
Both	38	5,901	5947.1	0.8
All Nonreclassified Hospitals	3,605	7,327	7351.4	0.3
All Urban Reclassified Hospitals	113	8,610	8615.0	0.1
Urban Nonreclassified Hospitals	11	5,794	5804.7	0.2
Standardized Amount Only	87	9,211	9195.4	−0.2
Wage Index Only	15	5,870	6047.1	3.0
Both	2,473	7,690	7699.1	0.1
All Reclassified Rural Hospitals	515	5,721	5829.0	1.9
Standardized Amount Only	11	4,848	5000.7	3.1
Wage Index Only	485	5,728	5835.5	1.9
Both	19	5,875	5981.2	1.8
Rural Nonreclassified Hospitals	1,094	4,516	4621.1	2.3
Other Reclassified Hospitals (Section 1886(D)(8)(B))	35	4,894	5026.9	2.7

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the changes for FY 2003 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2002 with the average estimated per case payments for FY 2003, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 8 of Table I.

VII. Impact of Specific Policy Changes

A. Impact of Changes Relating to Payment for the Clinical Training Portion of Clinical Psychology Training Programs

In section V.I.5. of the preamble to this final rule, we have revised our policy on Medicare payment for approved nursing and allied health education programs to permit payment for the costs incurred by a provider for the clinical training portion of clinical psychology training programs.

Our actuarial estimates indicate that there will be a fiscal impact of $40 million the first year after payments begin, growing to $50 million by the 5th year ($220 million over 5 years). Costs are expected to increase because we believe that Medicare's support through its education regulations will encourage hospitals to report more costs for clinical psychology training programs than are reported today. This estimate is based on assumptions as to how much Medicare could pay for additional educational programs and how quickly other providers with clinical training portions would begin seeking those payments.

The following chart shows projected costs to the Medicare program for the next 5 years:

Fiscal year	Medicare program costs (in millions)
2003	$40
2004	40
2005	40
2006	50
2007	50

B. Impact of Changes Relating to EMTALA Provisions

We are addressing proposed changes related to the EMTALA provisions in a separate final rule to be published at a later date.

C. Impact of Policy Changes Relating to Provider-Based Entity

In section V.K. of the preamble of this proposed rule, we discuss our proposed Medicare payment policy changes relating to determinations of provider-based status for entities of main providers. These changes are intended to focus mainly on issues raised by the hospital industry surrounding the provider-based regulations and to allow for a orderly and uniform implementation strategy once the grandfathering provision for these entities expires on September 30, 2002.

Because we believed it would be difficult to quantify the impact of these changes, in the May 9, 2002 proposed rule, we solicited comments on these issues. However, we received no comments that would assist us in developing a quantitative analysis of impact. Therefore, we are not able to prepare such an analysis.

VIII. Impact of Policies Affecting Rural Hospitals

A. Raising the Threshold To Qualify for the CRNA Pass-Through Payments

In section V. of the preamble of this final rule, we are raising the maximum number of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services that a rural hospital may perform to qualify for pass-through payments for the costs of CRNAs to 800 from 500. Currently, we have identified 622 hospitals that qualify under this provision.

To measure the impact of this provision, we determined that approximately half of the hospitals that would appear to be eligible based on the current number of procedures appear to receive this adjustment. In order to be eligible, hospitals must employ the CRNA and the CRNA must agree not to bill for services under Part B. We estimate approximately 90 rural hospitals would qualify under the increased maximum volume threshold. If one-half of these hospitals then met the other criteria, 45 additional hospitals would be eligible for these pass-through payments under this change.

B. Removal of Requirement for CAHs To Use State Resident Assessment Instrument

In section VII. of the preamble of this final rule, we are eliminating the requirement that CAHs use the State resident assessment instrument (RAI) to conduct patient assessments. There are approximately 600 CAHs. The overwhelming majority of CAHs, 95 percent, or approximately 270 CAHs, provide SNF level care. The elimination of the requirement to use the State RAI will greatly reduce the burden on CAHs because facilities will no longer be required to complete an RAI document for each SNF patient (which would involve approximately 12,000 admissions based on the most recent claims data). Facilities would have the flexibility to document the assessment data in the medical record in a manner appropriate for their facility. The elimination of the requirement for use of the State RAI will reduce the amount of time required to perform patient assessments and allow more time for direct patient care.

IX. Impact of Changes in the Capital Prospective Payment System

A. General Considerations

Fiscal year 2001 was the last year of the 10-year transition period established to phase in the prospective payment system for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the Federal rate and their hospital-specific rate (see § 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the Federal rate (see § 412.344). As we state in section VI.A. of the preamble of this final rule, the end of the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), capital prospective payment system payments for most hospitals are based solely on the Federal rate in FY 2003. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

In accordance with § 412.312, the basic methodology for determining a capital prospective payment system payment is: (Standard Federal Rate) x (DRG weight) x (Geographic Adjustment Factor(GAF)) x (Large Urban Add-on, if applicable) x (COLA adjustment for hospitals located in Alaska and Hawaii) x (1 + Disproportionate Share (DSH) Adjustment Factor + Indirect Medical Education (IME) Adjustment Factor, if applicable).

In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the March 2002 update of the FY 2001 MedPAR file and the March 2002 update of the Provider Specific File that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the June 2002 update of the most recently available hospital cost report data (FY 1999) to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the March 2002 update of the FY 2001 MedPAR file, we simulated payments under the capital prospective payment system for FY 2002 and FY 2003 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general hospital inpatient prospective payment systems (Indian Health Service Hospitals and hospitals in Maryland) are excluded from the simulations.

As we explain in section III.A.4. of the Addendum of this final rule, payments will no longer be made under the regular

exceptions provision under §§ 412.348(b) through (e). Therefore, we are no longer using the actuarial capital cost model (described in Appendix B of August 1, 2001 final rule (66 FR 40099)). We modeled payments for each hospital by multiplying the Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education, disproportionate share, large urban add-on, and outliers, if applicable. For purposes of this impact analysis, the model includes the following assumptions:

- We estimate that the Medicare case-mix index will increase by 0.99800 percent in FY 2002 and will increase by 1.01505 percent in FY 2003.
- We estimate that the Medicare discharges will be 13,398,000 in FY 2002 and 13,658,000 in FY 2003 for a 1.9 percent increase from FY 2002 to FY 2003.
- The Federal capital rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The FY 2003 update is 1.1 percent (see section III.A.1.a. of the Addendum to this final rule).
- In addition to the FY 2003 update factor, the FY 2003 Federal rate was calculated based on a GAF/DRG budget neutrality factor of 0.9957, an outlier adjustment factor of 0.9469, an exceptions adjustment factor of 0.9970, and a special adjustment for FY 2003 of 1.0255 (see section III.A. of the Addendum of this final rule).

2. Results

In the past, in this impact section we presented the redistributive effects that were expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals and a cross-sectional summary of hospital groupings by the capital prospective payment system transition period payment methodology. We are no longer including this information since all hospitals (except new hospitals under § 412.324(b) and under § 412.32(c)(2)) are paid 100 percent of the Federal rate in FY 2003.

We used the actuarial model described above to estimate the potential impact of our changes for FY 2003 on total capital payments per case, using a universe of 4,230 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the March 2002 update of the FY 2001 MedPAR file, the March 2002 update to the Provider-Specific File, and the most recent cost report data from the June 2002 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2002 compared to FY 2003 based on FY 2003 payment policies. Column 3 shows estimates of payments per case under our model for FY 2002. Column 4 shows estimates of payments per case under our model for FY 2003. Column 5 shows the total percentage change in payments from FY 2002 to FY 2003. The change represented in Column 5 includes the 1.1 percent update to the Federal rate, a 1.01505 percent increase in case-mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB, as well as changes in special exception payments. The comparisons are provided by: (1) geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 3.8 percent in FY 2003. Our comparison by geographic location shows an overall increase in payments to hospitals in all areas. This comparison also shows that urban and rural hospitals will experience slightly different rates of increase in capital payments per case (3.6 percent and 4.8 percent, respectively). This difference is due to a projection that urban hospitals will experience a larger decrease in outlier payments from FY 2002 to FY 2003 compared to rural hospitals.

All regions are estimated to receive an increase in total capital payments per case, partly due to the elimination of the 2.1 percent reduction to the Federal rate for FY 2003 (see section VI.D. of the preamble of this final rule). Changes by region vary from a minimum increase of 2.7 percent (Pacific urban region) to a maximum increase of 5.3 percent (East North Central rural region). Hospitals located in Puerto Rico are expected to experience an increase in total capital payments per case of 4.4 percent.

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (4.2 percent). Similarly, payments to voluntary hospitals will increase 4.1 percent, while payments to proprietary hospitals will increase 2.1 percent.

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both. Although the Federal capital rate is not affected, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes also affects the geographic adjustment factor, since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2003 compared to the effects of reclassification for FY 2002, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 2003 reclassifications, we indicate those hospitals reclassified for standardized amount purposes only, for wage index purposes only, and for both purposes. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 2003 as a whole are projected to experience a 4.5 percent increase in payments. Payments to nonreclassified hospitals will increase slightly less (3.7 percent) than reclassified hospitals, overall. Hospitals reclassified during both FY 2002 and FY 2003 are projected to receive an increase in payments of 4.1 percent. Hospitals reclassified during FY 2003 only are projected to receive an increase in payments of 8.6 percent. This increase is primarily due to changes in the GAF (wage index).

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2002 Payments Compared to FY 2003 Payments]

	Number of hospitals	Average FY 2002 payments/case	Average FY 2003 payments/case	Change
By Geographic Location:				
All hospitals	4,230	668	693	3.8
Large urban areas (populations over 1 million)	1,519	772	798	3.4
Other urban areas (populations of 1 million or fewer)	1,101	653	679	4.0
Rural areas	1,610	451	472	4.8
Urban hospitals	2,620	720	746	3.6
0–99 beds	645	511	532	4.2
100–199 beds	909	607	630	3.7
200–299 beds	523	692	718	3.7
300–499 beds	398	767	794	3.6
500 or more beds	145	933	964	3.4
Rural hospitals	1,610	451	472	4.8
0–49 beds	747	371	392	5.5
50–99 beds	501	412	434	5.3
100–149 beds	215	456	478	4.8

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2002 Payments Compared to FY 2003 Payments]

	Number of hospitals	Average FY 2002 payments/case	Average FY 2003 payments/case	Change
150–199 beds	78	494	517	4.7
200 or more beds	69	569	591	3.8
By Region:				
Urban by Region	2,620	720	746	3.6
New England	135	771	805	4.4
Middle Atlantic	404	807	829	2.8
South Atlantic	384	692	717	3.6
East North Central	429	688	720	4.6
East South Central	159	654	677	3.6
West North Central	178	706	736	4.3
West South Central	335	671	693	3.4
Mountain	132	694	728	4.8
Pacific	417	840	862	2.7
Puerto Rico	47	306	320	4.4
Rural by Region	1,610	451	472	4.8
New England	40	549	574	4.6
Middle Atlantic	67	473	496	4.9
South Atlantic	232	469	490	4.3
East North Central	215	457	482	5.3
East South Central	239	415	434	4.8
West North Central	279	443	466	5.2
West South Central	285	405	424	4.7
Mountain	145	467	490	5.0
Pacific	103	531	556	4.7
By Payment Classification:				
All hospitals	4,230	668	693	3.8
Large urban areas (populations over 1 million)	1,576	765	792	3.4
Other urban areas (populations of 1 million or fewer)	1,074	655	681	4.0
Rural areas	1,580	449	470	4.8
Teaching Status:				
Non-teaching	3,119	546	568	4.0
Fewer than 100 Residents	870	698	725	3.8
100 or more Residents	241	1,030	1,064	3.3
Urban DSH:				
100 or more beds	1,361	758	784	3.4
Less than 100 beds	286	482	502	4.2
Rural DSH:				
Sole Community (SCH/EACH)	470	394	414	5.1
Referral Center (RRC/EACH)	156	516	537	4.1
Other Rural:				
100 or more beds	76	419	438	4.6
Less than 100 beds	332	379	399	5.2
Urban teaching and DSH:				
Both teaching and DSH	757	836	864	3.4
Teaching and no DSH	284	750	781	4.2
No teaching and DSH	890	602	624	3.6
No teaching and no DSH	719	596	619	3.8
Rural Hospital Types:				
Non special status hospitals	577	399	419	5.0
RRC/EACH	160	528	549	4.0
SCH/EACH	526	417	438	5.1
Medicare-dependent hospitals (MDH)	241	372	394	5.9
SCH, RRC and EACH	76	507	532	5.0
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
Reclassification Status During FY2002 and FY2003:				
Reclassified During Both FY2002 and FY2003	573	585	610	4.1
Reclassified During FY2003 Only	54	525	570	8.6
Reclassified During FY2002 Only	77	764	758	−0.7
FY2003 Reclassifications:				
All Reclassified Hospitals	628	581	606	4.5
All Nonreclassified Hospitals	3,567	684	709	3.7
All Urban Reclassified Hospitals	113	780	814	4.4
Urban Nonreclassified Hospitals	2,473	719	745	3.6
All Reclassified Rural Hospitals	515	503	525	4.5
Rural Nonreclassified Hospitals	1,094	389	409	5.2
Other Reclassified Hospitals (Section 1886(D)(8)(B))	35	455	483	6.2
Type of Ownership:				
Voluntary	2,461	680	708	4.0
Proprietary	723	659	673	2.1

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2002 Payments Compared to FY 2003 Payments]

	Number of hospitals	Average FY 2002 payments/case	Average FY 2003 payments/case	Change
Government	869	604	629	4.2
Medicare Utilization as a Percent of Inpatient Days:				
0–25	310	864	892	3.3
25–50	1,613	766	792	3.5
50–65	1,677	583	607	4.1
Over 65	504	523	546	4.3

Appendix B: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Consistent with section 1886(e)(5)(B) of the Act, in this final rule we are publishing our final recommendations for updating hospital payments for FY 2003. In accordance with section 1886(d)(3)(A) and section 1886(b)(3)(B)(i)(XVIII) of the Act, we are updating the standardized amounts for FY 2003 equal to the rate of increase in the hospital market basket minus 0.55 percentage points for acute inpatient prospective payments to hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 2003 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate of increase in the market basket minus 0.55 percentage points.

Based on the revised and rebased second quarter 2002 forecast of the FY 2003 market basket increase of 3.5 percent, the update to the standardized amounts for hospitals subject to the acute inpatient prospective payment system is 2.95 percent (that is, the market basket rate of increase minus 0.55 percentage points) for hospitals in both large urban and other areas. The update to the hospital-specific rate applicable to SCHs and MDHs is also 2.95 percent. In the proposed rule, the market basket was 3.3 percent, for proposed update factors of 2.75 percent.

Under section 1886(b)(3)(B)(ii)(VIII) of the Act, the FY 2003 percentage increase in the rate-of-increase limits for hospitals and hospital units excluded from the acute inpatient prospective payment system is equal to the market basket percentage increase. Facilities excluded from the acute inpatient prospective payment system include psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, cancer hospitals, and children's hospitals.

In the past, hospitals and hospital units excluded from the acute inpatient prospective payment system have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid based on their reasonable costs are subject to TEFRA limits for FY 2003. For these hospitals, the update is the percentage increase in the excluded hospital market basket (currently estimated at 3.5 percent).

Inpatient rehabilitation facilities (IRFs) are paid under the IRF prospective payment system for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2003, the Federal prospective payment for IRFs is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually (see the August 7, 2001 final rule (66 FR 41316)).

Effective for cost reporting periods beginning during FY 2003, we have proposed that long-term care hospitals would be paid under a prospective payment system based on a 5-year transition period (see the March 22, 2002 proposed rule (67 FR 13416)). We also proposed that a long-term care hospital may elect to be paid on 100 percent of the Federal prospective payment rate at the beginning of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the proposed prospective payment system transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the long-term care hospital's TEFRA limit by the current estimate of the excluded hospital market basket (or 3.5 percent).

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish the update factors recommended under section 1886(e)(4) of the Act. Accordingly, we published the FY 2003 update factors recommended by the Secretary as Appendix C in the May 9, 2002 proposed rule (67 FR 31685). In that appendix, we discussed the recommendations of appropriate update factors and the analysis underlying our recommendations. We also responded to MedPAC's recommendations concerning the update factors.

II. Secretary's Final Recommendations for Updating the Prospective Payment System Standardized Amounts

In recommending an update, the Secretary takes into account the factors in the update framework, as well as other factors such as the recommendations of MedPAC, the long-term solvency of the Medicare Trust Funds, and the capacity of the hospital industry to continually provide access to high quality care to Medicare beneficiaries through adequate reimbursement to health care providers.

Comment: Numerous commenters pointed out the negative impact of reducing the market basket estimate by 0.55 percentage points. However, the commenters acknowledged that the statute requires an update to payments for FY 2002 of the market basket percentage increase minus 0.55 percentage points. One commenter stated that another year of ''market basket minus'' update was unsustainable.

Response: The commenters are correct that the 0.55 percentage point reduction from the market basket in calculating the update factor is required by statute.

Our final recommendation of the update is market basket minus 0.55 percentage points, which is consistent with current law, and does not differ from the proposed recommendation. However, the second quarter forecast of the market basket percentage increase is 3.5 for prospective payment hospitals (up from 3.3 percent estimated in the proposed rule). Thus, the Secretary's final recommendation is that the update to the prospective payment system standardized amounts for both large urban and other urban areas is 2.95 percentage points. The update to the hospital-specific rate applicable to SCHs and MDHs is also 2.95 percent (or consistent with current law, market basket percentage increase minus 0.55 percentage points).

III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals and Hospital Units

We received no comments concerning our proposed recommendation for updating the rate-of-increase for excluded hospitals and hospital units. Our final recommendation does not differ from the proposed recommendation. However, the second quarter forecast of the market basket percentage increase is 3.5 for excluded hospitals and hospital units (up from 3.4 percent estimated in the proposed rule).

For cost reporting periods beginning on or after October 1, 2002, the IRF prospective payment is based on 100 percent of the adjusted Federal IRF prospective payment system amount updated annually.

For purposes of the proposed long-term care hospital prospective payment system update factor, the portion of the transition blend payment based on reasonable costs for inpatient operating services for FY 2003 would be determined by updating the TEFRA target amount for long-term care hospitals by

the most recent available estimate of the increase in the excluded hospital operating market basket (or 3.5 percent).

Thus, the Secretary's final recommendation is that the update for the remaining hospitals and hospital units excluded from the acute inpatient prospective payment system is 3.5 percent.

[FR Doc. 02–19292 Filed 7–31–02; 8:45 am]

BILLING CODE 4120–01–P